HSGAC

MINORITY STAFF REPORT

MANUFACTURED CRISIS

How Better Negotiation Could Save Billions for Medicare and America's Seniors

REPORT TWO

U.S. Senate Homeland Security & Governmental Affairs Committee, Ranking Member's Office

Manufactured Crisis

How Better Negotiation Could Save Billions for Medicare and America's Seniors

EXECUTIVE SUMMARY

Prescription drug spending is projected to grow an average of 6.3% per year through 2025.[1] Unlike in many other industrialized nations, however, there is no centralized system in the United States for setting drug prices paid by the federal government. Instead, the various departments and agencies responsible for administering federal health programs operate under "a range of congressionally mandated drug discount and contracting systems, including market-based negotiations in Medicare Part D, direct procurement in the Veterans Health Administration, and a combination of mandatory rebates and negotiations in Medicaid."[2] Many of these agencies can use the Federal Supply Schedule—a multiple award, multi-year federal contract with price protections built in to secure lower drug prices. The Department of Veterans Affairs (VA) negotiates these prices directly with pharmaceutical companies[3] and maintains drug supply contracts for more than 10,000 pharmaceutical drugs, including all of the 20 most commonly prescribed brand-name drugs in the Medicare Part D program.[4] Using the VA's drug supply contracts, eligible federal agencies and programs can purchase brand-name drugs at a significantly lower rate than their list prices.[5] Agencies with the authority to negotiate directly with pharmaceutical companies, including the VA, can also negotiate additional discounts and pay even lower prices for certain drugs than prices listed on the negotiated Federal Supply Schedule.

The various contracting systems and negotiating efforts of government entities have produced wide differences in drug prices among federal drug benefit programs.[6] This report examines price variations for the 20 most commonly prescribed brand-name

[1] Centers for Medicare and Medicaid Services, *National Health Expenditure Projections 2016-2025* (www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2016.pdf).

[2] Congressional Research Service, *Frequently Asked Questions About Prescription Drug Pricing and Policy* (R44832) (Apr. 24, 2018) (fas.org/sgp/crs/misc/R44832.pdf).

[3] Government Accountability Office, *Drug Prices: Effects of Opening Federal Supply Schedule for Pharmaceuticals Are Uncertain* (GAO/HEHS-97-60) (June 1997) (www.gao.gov/assets/230/224182.pdf). Unless specified otherwise, all references and comparisons to "negotiated federal prices" in this report refer to drug prices listed on the Federal Supply Schedule (FSS). The VA negotiates FSS prices based on a vendor's most favored commercial customer pricing or statutorily-required pricing calculations. Department of Veterans Affairs, *Pharmacy Benefits Management Services* (June 3, 2015) (www.pbm.va.gov/PharmaceuticalPrices.asp) ("FSS is a multiple award, multi-year federal contract that satisfies all federal contract laws and regulations and is available for use by any federal government agency.").

[4] Department of Veterans Affairs, Office of Procurement, Acquisition and Logistics (OPAL), *Pharmaceutical Pricing Data* (www.va.gov/opal/nac/fss/pharmPrices.asp) (accessed June 12, 2018).

[5] Unless specified otherwise, all references to "list price" refer to Wholesale Acquisition Cost (WAC).

[6] Kalipso Chalkidou, Gerard Anderson, and Ruth Faden, *Eliminating Drug Price Differentials across Government Programmes in the USA*, Health Economics, Policy and Law (Jan. 26, 2011).

drugs in the Medicare Part D program by contrasting negotiated federal prices for these medications with their list prices. The sections below also consider how leveraging the purchasing power of the federal government—the largest pharmaceutical purchaser in the world—could result in lower drug prices across all government-sponsored drug benefit programs by comparing the actual amount spent by Medicare on these drugs to the amount Medicare would have spent using federally negotiated prices. Key findings include the following:

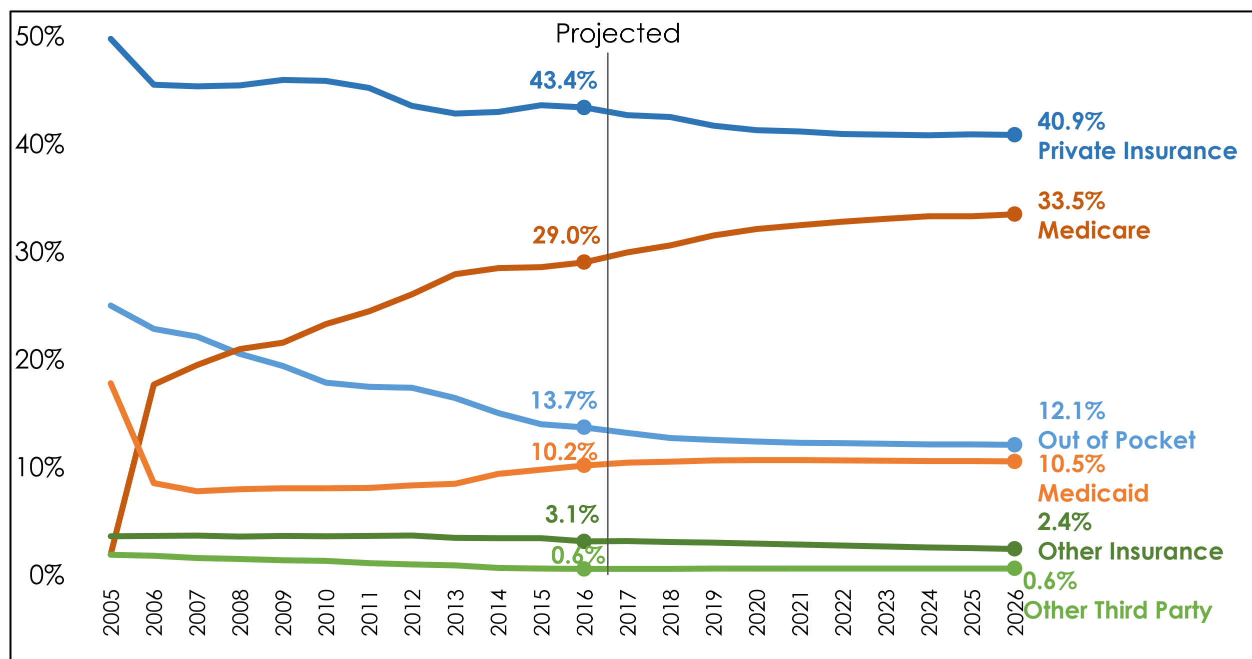
- The federal government spent over $139 billion on prescription drugs in 2016,[7] or 42.3% of the total prescription drug expenditure for the United States.[8]
- In 2016, the federal government spent $95.4 billion on prescription drugs in the Medicare program, primarily through the Medicare Part D program, which accounts for 14.2% of total Medicare expenditures and 29% of total prescription drug expenditure for the United States.[9]
- Negotiated federal drug prices rose at significantly lower rates than list prices for the top 20 most commonly prescribed brand-name drugs in Medicare Part D. After adjusting for inflation, the average price for these drugs in the Part D program rose from $151.58 to $241.09 between 2012 and 2017—an increase of 59.1%—compared to an increase in the average negotiated federal drug price from $104.10 to $149.88—an increase of 44.0%—for the same drugs during the same time period.
- Lower negotiated drug prices suggest the federal government could achieve lower drug prices for other federal agencies and programs, including Medicare Part D, if it successfully leveraged its significant purchasing power.
- Even when applying the CMS published average rebate amount—17.5%—for Medicare Part D brand-name drugs, and increasing negotiated federal prices by $13.46 to account for dispensing fees and other costs, Medicare and its beneficiaries could save a collective *$2.8 billion* in a single year under negotiated federal prices for the top 20 most commonly prescribed brand-name drugs *alone*.

[7] Annual figures and calculations included in this report refer to calendar year figures, rather than fiscal years.
[8] Centers for Medicare and Medicaid Services, *National Health Expenditure Projections 2017-2026, Table 11 Prescription Drug Expenditures; Aggregate and Per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds* (Feb. 16, 2018) (go.cms.gov/2klUusj).
[9] *Id.*

BACKGROUND

In 2016, national health spending increased 4.3%, with the total amount Americans spend on health care reaching $3.3 trillion.[10] American health care spending is projected to grow at an average rate of 5.5% per year between 2017 and 2026 and to reach $5.7 trillion by 2026.[11] The federal, state, and local government share of national health care spending in 2016 grew by more than 4.4% to $1.5 trillion—roughly 45% of the total—and is forecasted to rise to more than $2.7 trillion by 2025.[12] The federal government's share of U.S. prescription drug spending (federal, state, and local) rose from around 25% in 2005 to an estimated 44.1% in 2017.[13] *See* **Figure 1.**

Figure 1: Prescription Drug Spending by Payment Source[14]



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[10] Centers for Medicare and Medicaid Services, NHE Fact Sheet (www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html) (accessed June 12, 2018).
[11] *Id.*
[12] Centers for Medicare and Medicaid Services, *National Health Expenditure Projections 2016-2025* (Feb. 15, 2017) (www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2016.pdf); Centers for Medicare and Medicaid Services, *National Health Expenditure Projections 2017-2026* (Feb. 16, 2018) (www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf); Centers for Medicare and Medicaid Services, *National Health Expenditure Projections 2017-2026, Table 16 National Health Expenditures, Amounts and Average Annual Growth from Previous Year Shown, by Type of Sponsor* (Feb. 16, 2018) (go.cms.gov/2klUusj).
[13] Congressional Research Service, *Frequently Asked Questions About Prescription Drug Pricing and Policy* (R44832) (Apr. 24, 2018) (fas.org/sgp/crs/misc/R44832.pdf).
[14] "Other Insurance" includes the Children's Health Insurance Program (CHIP) (Titles XIX and XXI), the Department of Defense, and the Department of Veterans Affairs. "Other Third Party" includes worksite health care, other private revenues, the Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, other federal programs, the Substance Abuse and Mental Health Services Administration, other state and local programs, and school health. Centers for Medicare and Medicaid Services, *National Health Expenditure Projections 2017-2026,Table 11 Prescription Drug Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds* (Feb. 16, 2018) (go.cms.gov/2klUusj).

Other than private insurance, the Medicare program accounts for the highest expenditures for prescription drugs in the United States. In 2016, for example, the Medicare program accounted for 29% of all retail prescription spending—for a total of $95.4 billion, a number expected to rise to $202.5 billion—33% of projected spending—in 2026.[15] This surge will arise from an increasing number of seniors enrolling in Medicare—including Medicare Part D, the largest federal pharmaceutical drug purchasing program.[16]

Unlike in many other industrialized nations, however, there is no centralized system in the United States for setting drug prices paid by the federal government. Instead, the various departments and agencies responsible for administering federal health programs operate under distinct drug discount and contracting systems.[17] The Department of Veterans Affairs (VA), for example, negotiates drug prices directly with pharmaceutical companies[18] and maintains drug supply contracts for more than 10,000 pharmaceutical drugs on the Federal Supply Schedule (FSS).[19] Other agencies, including the Department of Defense (DOD), Public Health Service, U.S. territorial governments, and many Indian Tribal governments, can use the contracts VA negotiates to order prescription drugs.[20] The "Big 4" agencies—DOD, VA, the Public Health Service, and the Coast Guard—represent the four largest federal purchasers of prescription drugs and account for over 95% of purchases under negotiated federal contracts. These entities can also receive additional discounts through other negotiations with manufacturers and pay even less than the FSS prices for certain drugs.[21] Finally, the Big 4 also receive a discount from companies under a statutory federal ceiling price—a mandatory reduction on the average manufacturer price that often applies to FSS list prices.[22]

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[15] Centers for Medicare and Medicaid Services, *National Health Expenditure Projections 2017-2026, Table 11 Prescription Drug Expenditures; Aggregate and Per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds* (Feb. 16, 2018) (go.cms.gov/2klUusj).
[16] Centers for Medicare and Medicaid Services, *National Health Expenditure Projections 2017-2026* (Feb. 16, 2018) (www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf); *see also* Department of Health and Human Services, Office of the Actuary, *Brief Summaries of Medicare & Medicaid: Title XVIII and Title XIX of the Social Security Act* (Nov. 20, 2017) (go.cms.gov/2s5nvfS); Centers for Medicare and Medicaid Services, *National Health Expenditure Projections 2017-2026: Tables* (Feb. 16, 2018) (go.cms.gov/2klUusj).
[17] Congressional Research Service, *Frequently Asked Questions About Prescription Drug Pricing and Policy* (R44832) (Apr. 24, 2018) (fas.org/sgp/crs/misc/R44832.pdf).
[18] The government negotiates FSS prices based on a vendor's most favored commercial customer pricing or statutorily-required pricing calculations. *See* Department of Veterans Affairs, *Pharmacy Benefits Management Services* (www.pbm.va.gov/PharmaceuticalPrices.asp) (accessed June 3, 2018) ("FSS is a multiple award, multi-year federal contract that satisfies all federal contract laws and regulations and is available for use by any federal government agency."); *see also* Government Accountability Office, *Drug Prices: Effects of Opening Federal Supply Schedule for Pharmaceuticals Are Uncertain* (GAO/HEHS-97-60) (June 1997) (www.gao.gov/assets/230/224182.pdf).
[19] Department of Veterans Affairs, Office of Procurement, Acquisition and Logistics (OPAL), *Pharmaceutical Pricing Data* (www.va.gov/opal/nac/fss/pharmPrices.asp) (accessed May 8, 2018).
[20] Congressional Budget Office, *Prices for Brand-Name Drugs Under Selected Federal Programs* (June 2005) (www.cbo.gov/sites/default/files/cbofiles/ftpdocs/64xx/doc6481/06-16-prescriptdrug.pdf).
[21] *Id.* Prices for the Big 4 agencies are based on pricing calculations outlined under federal law. In addition, the Big 4 entities often enjoy further exclusive discounts on medications. Department of Veterans Affairs, *Pharmacy Benefits Management Services* (www.pbm.va.gov/PharmaceuticalPrices.asp) (accessed May 8, 2018).
[22] *See* 38 U.S.C. § 8126.

Despite the significant share of prescription spending attributable to the Medicare program—and projected increases in costs—federal law prevents the government from negotiating Medicare Part D drug prices directly with pharmaceutical manufacturers. Specifically, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003—which created the Part D benefit—included a "noninterference provision" that prohibits the Secretary of the Department of Health and Human Services (HHS) from requiring a specific Part D drug formulary or intervening in negotiations between Part D plan sponsors, drug manufacturers, and pharmacies.[23] As a result, Medicare Part D commercial health sponsors—including health plans, unions, employers, and pharmacy benefit managers (PBM)—carry the responsibility of setting reimbursement rates, negotiating drug prices with manufacturers, and contracting with retail pharmacies to dispense drugs to Part D enrollees.[24] This market-based private negotiation process between Medicare Part D plan administrators and pharmaceutical manufacturers often results in inconsistent drug prices for identical drugs among Part D plans.[25]

In contrast, the VA—which operates the largest integrated direct health care delivery system in the United States, serving approximately 9 million veteran patients[26]—uses various contracting mechanisms to negotiate drug prices directly with pharmaceutical manufacturers. VA also implements a national formulary that includes all of the 20 most commonly prescribed brand-name drugs in the Medicare Part D program. While the VA's negotiated federal contracts provide the ceiling price for VA drug purchases, the VA also participates in the VA National Contract program, a separate contract vehicle that allows the VA to negotiate additional discounts directly with pharmaceutical companies.[27] Consequently, the VA National Contract program generally results in lower pricing than the negotiated federal contract prices.[28] Drug manufacturers, in turn, must make their brand-name drugs available through the negotiated federal contracts to receive reimbursements for medications covered by Medicaid.[29] Under this system, VA and other eligible federal agencies and programs can purchase brand-name drugs at a fraction of the advertised list prices for these drugs.[30]

Medicare beneficiaries participate in cost sharing with the federal government and prescription drug plans. Unlike other federal drug benefit programs with a fixed dollar amount—or copayment—for prescription drugs, Medicare beneficiaries are generally required to pay coinsurance—a percentage of the cost of the drug—under the cost-

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[23] Congressional Research Service, *Frequently Asked Questions About Prescription Drug Pricing and Policy* (R44832) (Apr. 24, 2018) (fas.org/sgp/crs/misc/R44832.pdf).
[24] *Id.*
[25] *See* Kaiser Family Foundation, *It Pays to Shop: Variation in Out-of-Pocket Costs for Medicare Part D Enrollees in 2016* (Dec. 2, 2015) (www.kff.org/report-section/it-pays-to-shop-variation-in-out-of-pocket-costs-for-medicare-part-d-enrollees-in-2016-findings/).
[26] Department of Veterans Affairs, Veterans Health Administration: About VHA (www.va.gov/health/aboutvha.asp) (accessed July 17, 2018).
[27] VA National Contracts are "requirement-type contracts that offer additional pricing concessions in return for commitment to potential vendors." Department of Veterans Affairs, Office of Procurement, Acquisition and Logistics (OPAL), Pharmaceutical Prices (www.va.gov/opal/nac/fss/pharmPrices.asp) (accessed May 24, 2018).
[28] *Id.*
[29] Government Accountability Office, *Drug Prices: Effects of Opening Federal Supply Schedule for Pharmaceuticals Are Uncertain* (GAO/HEHS-97-60) (June 1997) (www.gao.gov/assets/230/224182.pdf).
[30] *Id.*

sharing structure.[31] As a result, when drug prices increase, Medicare beneficiaries pay higher prices for the same drugs to continue covering their portion of the shared costs. In contrast, beneficiaries of other federal drug benefit programs use set copayments under which they pay a fixed dollar amount for each item or service and continue to pay the same fixed amount regardless of drug price increases.[32]

METHODOLOGY

At the request of Ranking Member McCaskill, the minority staff of the Committee on Homeland Security and Governmental Affairs analyzed drug pricing data for the 20 most commonly prescribed brand-name drugs in Medicare Part D. Staff compared average Medicare Part D spending on these 20 drugs across a nationally representative sample of the U.S. population to corresponding negotiated federal prices. Staff collected and reviewed data from the VA Office of Acquisition and Logistics, which manages pharmaceutical pricing data for all VA National Acquisition Center programs.

Staff also reviewed VA biweekly pricing data and calculated average biweekly pricing numbers to determine annual negotiated federal pricing numbers. Staff adjusted all drug prices to account for inflation by normalizing to a 2017 constant dollar value using the Consumer Price Index for All Urban Consumers (CPI-U) to enable a more accurate comparison across the 2012-2017 time period.

Staff also reviewed Big 4 and National Contract price data and found, generally, that Big 4 and National Contract prices were lower than FSS prices. While the data suggests that eligible agencies engaging in direct negotiations with pharmaceutical companies can secure more favorable pricing and additional discounts on specific drugs, staff did not evaluate the potential cost savings for individual drugs using Big 4 or National Contract prices.[33] Additional information regarding methodology can be found in the Appendix.

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[31] Avalere Health, *Majority of Drugs Now Subject to Coinsurance in Medicare Part D Plan* (Mar. 10, 2016) (avalere.com/expertise/managed-care/insights/majority-of-drugs-now-subject-to-coinsurance-in-medicare-part-d-plans).

[32] *Id.*

[33] Big 4 and National Contract Price data is included in this report for comparison purposes only. Big 4 prices are subject to the statutory federal ceiling price under 38 U.S.C. § 8126. National Contract prices are based on negotiations between the VA and manufacturers based on formularies.

ON AVERAGE, VA'S NEGOTIATED FEDERAL CONTRACT DRUG PRICES ARE SIGNIFICANTLY LOWER THAN PRICES PAID BY MEDICARE FOR THE MOST COMMONLY PRESCRIBED PART D BRAND-NAME DRUGS

Staff found that VA's negotiated federal drug prices for the most commonly prescribed brand-name Medicare Part D drugs rose at significantly lower rates than list prices for the top 20 most commonly prescribed brand-name drugs in Medicare Part D.[34] After adjusting for inflation, staff found that the average price for the top 20 most commonly prescribed drugs in the Part D program rose from $151.58 to $241.09 between 2012 and 2017—an increase of 59.1%.[35] On average, the negotiated federal drug prices for the same brand-name drugs rose from $104.10 to $149.88—an increase of 44.0%—during the same time period,[36] after adjusting for inflation.[37]

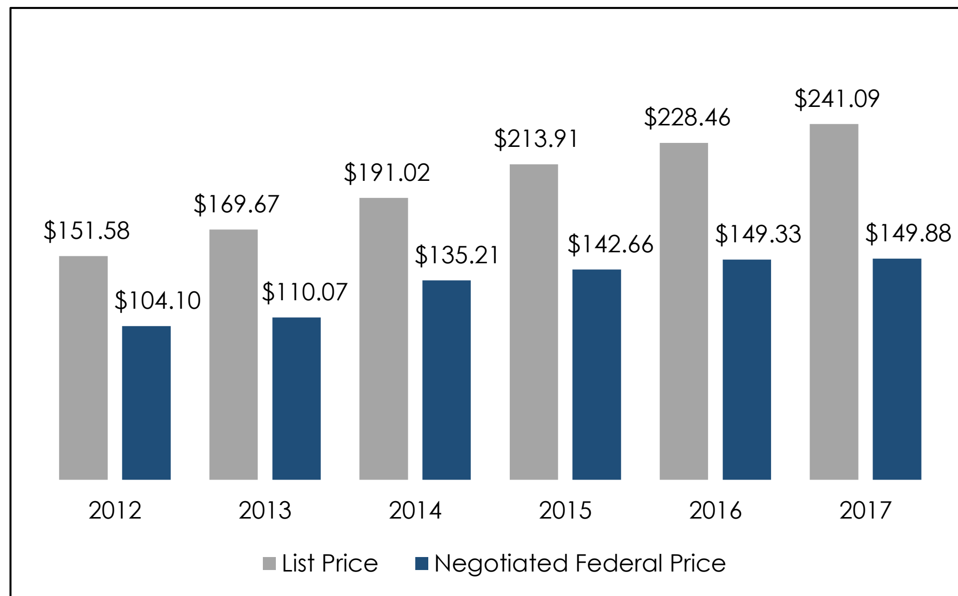
[34] HSGAC minority staff previously analyzed price increases for the top 20 most commonly prescribed brand-name drugs in the Medicare Part D program. *See* Ranking Member Claire McCaskill, *Manufactured Crisis: How Devastating Drug Price Increases Are Harming America's Seniors* (Mar. 26, 2018). This report expands on that work, using additional data to compare list prices for the most popular packaging form—or "top unit pack"—of each drug to corresponding negotiated federal contract prices. *See* Figures 2 and 3.

[35] This average weighted WAC price reflects the average price for the "basket" of the 20 most commonly prescribed brand-name drugs in the Medicare Part D program. The basket includes these drugs weighted in proportion to the total amount of prescriptions written nationwide for each drug.

[36] Price comparisons reflect a change in list price adjusted for inflation in the Medicare Part D program and the FSS price without accounting for any additional rebates or negotiated discounts.

[37] Staff did not obtain separate data for Lantus and Lantus Solostar. Instead the data is weighted according to Part D usage (45% for Lantus and 55% for Solostar). Staff also did not have VA pricing data (FSS, Big 4, or NC) for Nitrostat in 2012 and instead adjusted the weighting for the 2012 FSS basket to exclude this anomaly. Given that Nitrostat only accounts for 0.2% of prescriptions among the 20 most commonly prescribed brand-name drugs in Medicare Part D, the effect of this change was minimal.

Figure 2: Comparison of Average List Prices and Negotiated Federal Contract Prices for the 20 Most Commonly Prescribed Medicare Part D Brand-Name Drugs, 2012-2017[38]



For nearly all of the 20 most commonly prescribed brand-name drugs in the Medicare Part D program, the negotiated federal drug prices ranged from roughly 30% to 80% of the list prices for the same medication.[39] The negotiated federal drug prices for seven of the 20 most commonly prescribed drugs are *less than half* of the list prices. In 2017, for example, the list price for Nitrostat[40] was $108.76, while the negotiated federal drug price for Lantus was $46.24or roughly 43% of the list price. Similarly, under Big 4 pricing to VA, DOD, the Public Health Service, and the Coast Guard, the price for Nitrostat—$24.98—was roughly 23% of the list price. In fact, *only one drug*, NovoLog FlexPen,[41] had a negotiated federal drug price exceeding the list price—$144.95 under the negotiated federal price, or 138% of the list price of $105.28.

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[38] Staff used a "best available" method to calculate weighted average drug prices for each of the four categories (WAC, FSS, Big 4, and NC) for the basket of the 20 most commonly prescribed brand-name drugs in Medicare Part D. For example, when calculating the National Contract average for the basket of drugs, if National Contract price was not available for a specific drug in a specific year, staff used Big 4 pricing. If the Big 4 price was also not available, staff used FSS pricing for that drug as a fallback. Nitrostat was not listed in VA pricing files from 2012 and is therefore excluded from the 2012 basket. Prices are in 2017 constant dollars.

[39] Rebates and other price concessions negotiated independently of CMS will impact the final cost of prescription drugs in the Medicare Part D program. *See* Centers for Medicare and Medicaid Services, *Fact Sheet: Medicare Part D – Direct and Indirect Remuneration (DIR)* (Jan. 19, 2017) (www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-01-19-2.html). CMS has noted, however, that cost-sharing for Part D beneficiaries "is calculated based on the drug price at the point-of-sale, without regard to rebates and other price concessions received after the point-of-sale. Therefore, while [these concessions] may hold down total [Part D] program expenses (and beneficiary premiums), it does not reduce the cost of drugs for beneficiaries at the point-of-sale." *Id.*

[40] *See* Pfizer, Nitrostat® (sublingual tablet) 0.4 mg (www.pfizermedicalinformation.com/en-us/nitrostat) (accessed July 26, 2018) (describing Nitrostat as a "nitrate vasodilator indicated for relief of an attack or prophylaxis of angina pectoris due to coronary artery disease").

[41] *See* Novo Nordisk, NovoLog® FlexPen® | NovoLog® (insulin aspart injection) 100 U/mL (www.novologpro.com/prescribing/insulin-pens/novolog-flexpen.html) (accessed May 7, 2017) (describing NovoLog FlexPen as "an insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus").

Figure 3: List Prices and Negotiated Federal Prices of Individual Drugs, 2017[42]

Product	List Price	Negotiated Federal Price
Advair Diskus	$ 361.40	$ 269.20
Crestor	$ 260.90	$ 80.79
Januvia	$ 391.24	$ 270.23
Lantus	$ 250.24	$ 76.74
Lantus Solostar	$ 375.50	$ 130.69
Lyrica	$ 598.32	$ 460.70
Nexium	$ 250.94	$ 145.85
Nitrostat	$ 108.76	$ 46.24
Novolog FlexPen	$ 105.28	$ 144.95
Premarin	$ 519.91	$ 282.90
Proair HFA	$ 54.08	$ 49.11
Restasis	$ 232.57	$ 136.49
Spiriva Handihaler	$ 368.20	$ 170.53
Symbicort	$ 308.68	$ 170.51
Synthroid	$ 101.14	$ 8.89
Tamiflu	$ 144.49	$ 141.12
Ventolin HFA	$ 52.18	$ 36.83
Voltaren Gel	$ 50.96	$ 24.90
Xarelto	$ 385.81	$ 222.63
Zetia	$ 313.80	$ 259.46
Zostavax	$ 2,126.66	$ 1,839.32

POTENTIAL COST SAVINGS FROM PROVIDING MEDICARE PART D ACCESS TO NEGOTIATED FEDERAL DRUG PRICING

According to a 2008 academic study, if Medicare Part D had access to negotiated federal pricing for the top 200 drug formulations dispensed to seniors, annual federal savings would reach $21.9 billion.[43] To determine the potential cost savings from applying more recent negotiated federal pricing, staff replicated the methodology of the 2008 study to compare Medicare Part D spending for the 20 most commonly prescribed brand-name drugs to spending under negotiated federal drug prices.[44]

[42] This chart reflects list pricing and negotiated federal pricing for the top 20 most commonly prescribed brand-name drugs in the Medicare Part D program. The prices for Lantus and Lantus Solostar are broken out separately to provide additional detail. As mentioned above, staff used list prices for the most popular packaging form of each drug in 2017—or "top unit pack"—to allow for a direct comparison to corresponding negotiated federal prices.
[43] Walid F. Gellad, et al., *What if the Federal Government Negotiated Pharmaceutical Prices for Seniors? An Estimate of National Savings*, Journal of General Internal Medicine (Sept. 2008).
[44] *See* Methodology Addendum.

Staff found that even when accounting for a 17.5% average rebate for Medicare Part D brand-name drugs, and increasing negotiated federal prices by $13.46 to account for dispensing costs, Medicare and its beneficiaries would save a collective *$2.8 billion* under negotiated federal prices for the top 20 most commonly prescribed brand-name drugs *alone*.[45]

CONCLUSION

The federal government is the largest purchaser of pharmaceutical drugs in the world. Yet unlike many other industrialized countries, the United States does not use its significant purchasing power to negotiate directly with pharmaceutical companies to secure lower drug prices for all federal drug benefit programs. Instead, Medicare Part D plan administrators carry the responsibility for negotiating drug prices directly with pharmaceutical manufacturers. As a result, Medicare Part D drug prices for the most commonly prescribed brand-name drugs continue to soar, even as drug prices for a single, identical drug may vary among Medicare Part D benefit plans.

In other drug benefit programs in which the federal government has successfully leveraged its significant purchasing power, it has secured lower prices from manufacturers for drugs listed on the Federal Supply Schedule. In almost every case, Medicare Part D costs for the most commonly prescribed brand-name drugs far exceed the costs incurred by federal drug benefit programs eligible to purchase drugs through this schedule. The significant variation between Medicare Part D drug prices and negotiated federal drug prices—and the potential costs savings from extending negotiated prices to other federal drug benefit programs—merits further investigation.

[45] "MEPS estimates [are] 10 percent lower on average than estimates from MarketScan." Ana Aizcorbe, et al., *Measuring Health Care Costs of Individuals with Employer-Sponsored Health Insurance in the U.S.: A Comparison of Survey and Claims Data*, Statistical Journal of the International Association for Official Statistics (IAOS) (2012). Therefore, calculated price savings from applying negotiated federal drug prices to drugs in Medicare Part D are conservative; actual savings may be significantly higher. *See also* Didem Bernard, et al., *Reconciling Medical Expenditure Estimates from the MEPS and NHEA, 2007*, Medicare & Medicaid Research Review (2012).

APPENDIX

A. Methodology Addendum

To compare Medicare Part D drug prices to FSS Prices, staff used the latest available FSS price for 2015 for each National Drug Code (NDC).[46] Staff standardized the FSS pricing data according to corresponding size and strength of each drug available and compared FSS pricing data to total Medicare Part D expenditures on the same drugs using the 2015 Medical Expenditure Panel Survey (MEPS). Staff selected all entries with a non-zero amount paid by Medicare (variable name RXMR15X) to isolate Medicare expenditures and exclude expenditures by other non-Medicare payors.[47] The matched set was limited to drugs contained in the March 23, 2018, minority staff report. MEPS entries were matched to their negotiated federal prices using the NDC and, if this match could not be established, using the drug name, strength, and size (in cases where multiple sizes were available in FSS).

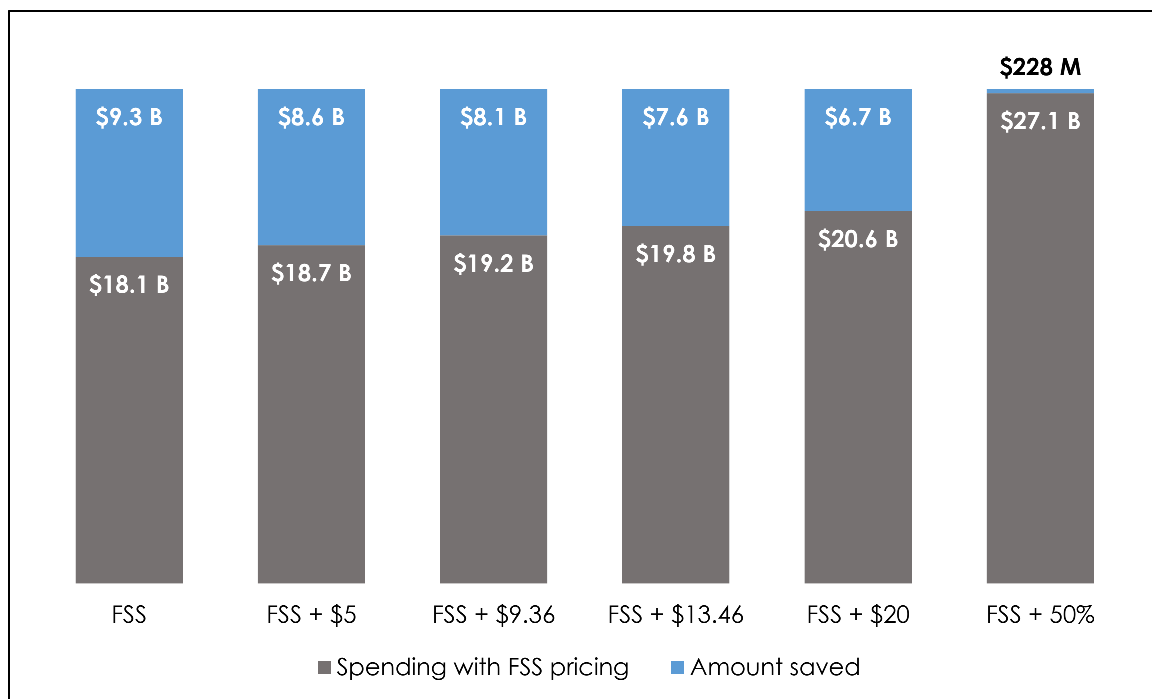
Under MEPS, each person is assigned a weight according to his or her demographics to enable nationally representative estimates. A person with a weight of 10,000, for instance, would represent 10,000 people in a national estimate. To estimate national spending, equivalent spending under FSS, and savings from FSS, staff multiplied each of the three columns for each MEPS entry by the person weight. To calculate the equivalent FSS cost of each MEPS entry, staff multiplied the base FSS price by the ratio of MEPS package size divided by FSS package size. For example, if the FSS price for a package of 30 pills cost $100, but the MEPS data reflected spending for a prescription for 15 pills, the equivalent FSS cost was calculated as $100 x (15/30) = $50. Staff standardized drug prices by volume in order to compare FSS pricing to the total amount spent by Medicare Part D according to MEPS data, including any applicable copays or coinsurance to determine potential savings. For example, if the MEPS amount paid was $75 for 15 pills, then the potential cost savings under FSS for 15 pills would be calculated as $75 - $50 = $25.

Staff built a sensitivity analysis to account for costs reflected in the MEPS figures that are not included in the FSS price, such as pharmacy dispensing fees. Dispensing fees vary by drug and plan sponsor; a 2014 Department of Health and Human Services Office of Inspector General report found that average dispensing fees range from roughly $1.81 to $4.65 for a variety of drug types, and a staff analysis of information in a 2016 study commissioned by the Ohio Department of Medicaid indicated a $13.46 average cost of dispensing within the state. Staff used this $13.46 figure to estimate average dispensing costs. Staff also used sensitivity analysis to account for Medicare rebates by observing the amount saved when FSS prices are closer to MEPS prices. According to data from the Centers for Medicare and Medicaid Services, the average rebate for brand-name prescription drugs in Medicare Part D programs was 17.5% in 2014.

[46] *See* Department of Veterans Affairs, Office of Acquisition and Logistics (OAL), Freedom of Information Act (FOIA) Library, Historical VA Pharmaceutical Prices (www.va.gov/oal/business/pps/foiaLibrary.asp) (accessed June 12, 2018).
[47] Department of Health & Human Services, *MEPS HC-178A: 2015 Prescribed Medicines File* (July 2017) (meps.ahrq.gov/data_stats/download_data/pufs/h178a/ h178adoc.shtml).

In 2015, Medicare spent a combined $27.3 billion on the 20 most commonly prescribed brand-name drugs in Medicare Part D. **Figure 4** below shows that Medicare Part D could save up to $9.3 billion if it were able to purchase these 20 drugs at negotiated federal contract prices—without accounting for any Medicare rebate spending. Assuming an average $13.46 price markup over negotiated federal prices to account for dispensing costs, as discussed above, the program could still save up to $7.6 billion compared to current spending. Even if Medicare Part D purchased drugs at a 50% markup above FSS prices—meaning Medicare Part D would still need to pay 50% more than the maximum negotiated federal drug price that other federal agencies pay for the same drug to account for rebates and other expenses—Medicare Part D could still save an estimated $228 million. **Figure 4** illustrates the savings for Medicare Part D assuming the program purchased drugs at a variety of markups above the negotiated federal prices.

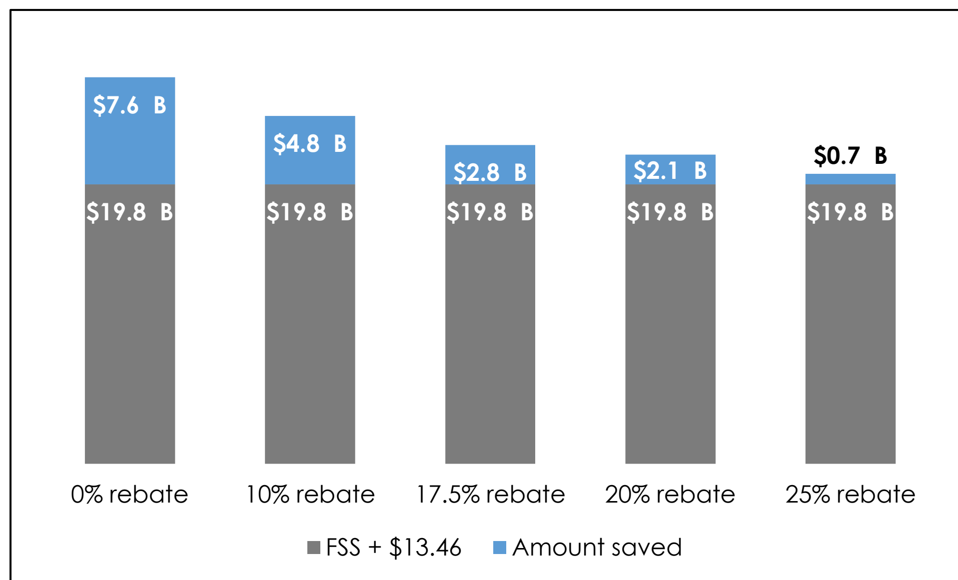
Figure 4: Savings Under Negotiated Federal Pricing, Assuming No Medicare Rebates[48]



48 The $9.36 figure is included in Figure 4 because the Ohio study mentioned above indicated this amount represented the average cost of dispensing prescription drugs at retail community pharmacies alone. *See* Mercer Government Human Services Consulting, *Professional Dispensing Fee Analysis for Medicaid Members – Pharmacy Survey Report, Ohio Department of Medicaid* (Nov. 28, 2016) (pharmacy.medicaid.ohio.gov/sites/default/files/oh-pdfs-2016-report.pdf).

Figure 5 below presents potential cost savings after accounting for manufacturer rebates and similar savings not reflected in negotiated federal prices.[49] Using the 17.5% average rebate for brand-name prescription drugs in the Medicare Part D program and still assuming a $13.46 markup over negotiated federal prices to account for dispensing costs, this chart shows that Medicare Part D could still save an estimated $2.8 billion if it were able to purchase the top 20 brand-name drugs at the negotiated federal prices.

Figure 5: Savings Under Negotiated Federal Pricing with Escalating Medicare Rebate Amounts, Assuming FSS + $13.46 Pricing[50]



[49] Because Medicare rebate information is not publicly available, staff estimated Medicare savings by comparing total Medicare spending to FSS pricing + $13.46 for rebate values based on the average rebate rate published by CMS of 17.5%. *See* Centers for Medicare and Medicaid Services, *Manufacturer Rebate Summary Report* (Dec. 7, 2016) (www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Information-on-Prescription-Drugs/2014_PartD_Rebates.html). Staff added $13.46 to FSS drug prices to account for dispensing costs included in total MEPS spending.

[50] Staff estimated Medicare savings by comparing total Medicare spending to FSS pricing + $13.46 for rebate values of 0%, 10%, 17.5%, 20% and 25%. As the rebate amount manufacturers provide to Medicare increases, total Medicare spending correspondingly decreases, resulting in less savings under negotiated prices. Staff added $13.46 to FSS drug prices to account for dispensing costs included in total MEPS spending but not included in FSS prices.

B. Prices of Top 20 Most Commonly Prescribed Brand-Name Drugs in Medicare Part D in 2017 (in dollars)

Drug	Pack Description	List price	Negotiated Federal Price	Big 4[51]	National Contract
ADVAIR DISKUS 03/2001 GSK	DISK W/DEV 250-50MCG 60	361.40	269.20	220.23	
CRESTOR 08/2003 AZN	TAB 40MG 30	260.90	80.79	80.79	
JANUVIA 10/2006 MSD	TAB FC 100MG 30UOU	391.24	270.23	238.92	
LANTUS 05/2001 S.A	VIAL WET MD 100U/ML 10ML	250.24	76.74	72.59	
LANTUS SOLOSTAR 07/2007 S.A	DEVICE PRF 100U/ML 3MLX5	375.50	130.69	130.52	
LYRICA 08/2005 PFZ	CAP 75MG 90	598.32	460.70	423.79	
NEXIUM 03/2001 AZN	CAP DR 40MG 30UOU	250.94	145.85	145.85	
NITROSTAT 05/1975 PFZ	TAB SL .4MG 4X25	108.76	46.24	24.98	
NOVOLOG FLEXPEN 02/2003 N-N	DEVICE PRF 100 U/ML 3ML	105.28	144.95	144.95	30.48
PREMARIN 01/1942 PFZ	TAB .625MG 100	519.91	282.90	257.79	
PROAIR HFA 12/2004 T9V	MDI W/COUNTE90MCG 8.5GM	54.08	49.11	36.29	10.05
RESTASIS 03/2003 ALL	VIAL EMUL OP .05% 0.4MLX30	232.57	136.49	135.45	
SPIRIVA HANDIHALER 05/2004 B.I	CAP INH 18MCG 30	368.20	170.53		
SYMBICORT 06/2007 AZN	MDI 160-4.5MCG 10.2GM	308.68	170.51	170.51	24.00
SYNTHROID 12/1963 AV1	TAB .1MG 90	101.14	8.89		
TAMIFLU 11/1999 ROC	PWD SUSP 6MG/ML 60ML	144.49	141.12	89.21	
VENTOLIN HFA 02/2002 GSK	MDI 90MCG 18GM 0682-20	52.18	36.83	31.99	
VOLTAREN GEL 04/2008 END	GEL 1% 100GM	50.96	24.90		
XARELTO 07/2011 JAN	TAB 20MG 30	385.81	222.63	221.85	
ZETIA 11/2002 MSD	TAB 10MG 30UOU	313.80	259.46	147.52	
ZOSTAVAX 06/2006 MSD[52]	VIAL DRY SD 19.4MU 1X10	2,126.66	1,839.32	1,348.36	

[51] Big 4 prices were not available for all 20 drugs.
[52] The Zostavax pack size is ten doses.