No Bargain:

Medicare Drug Plans Deliver High Prices

A REPORT BY

Families USA

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INTRODUCTION

When the Medicare Part D prescription drug legislation was being developed, Congress and the Bush Administration decided to specifically prohibit the Medicare program from bargaining with pharmaceutical companies to secure lower drug prices. This controversial decision took the responsibility for moderating drug prices away from the Medicare program and, instead, placed it in the hands of private drug plans. One full year after the implementation of Part D, the unfortunate consequence of this decision is clear—private plans have failed to deliver low prices.

The ability of private plans to secure low drug prices is critically important, both to America's seniors and to taxpayers. Drug prices set by private Part D plans significantly affect premiums and how much beneficiaries end up paying out of pocket overall. These drug prices also have a direct effect on the burden borne by taxpayers, who pay approximately three-fourths of the costs of the Part D program.

Proponents of the ban on Medicare negotiations make two contradictory claims in support of their position. First, they claim that direct negotiation by Medicare would not secure lower prices than those obtained by private market competition. Second, they argue that direct negotiation would reduce prices so significantly that it would force drug manufacturers to cut back on research and development (R&D), thereby jeopardizing pharmaceutical innovation. These arguments cannot both be true—and, indeed, neither is true.

To assess the merits of these two claims, Families USA analyzed the drug prices that Part D plans charge for the 20 drugs most frequently prescribed to seniors. We examined prices for each of the plans offered by the five largest Part D insurers. Combined, these five insurers serve about two-thirds of all Part D beneficiaries (Table 1). Because these companies

Table 1

Top Part D Insurers, by Market Share

Company	Enrollees	Market Share
UnitedHealthcare/PacifiCare	3,796,500	27%
Humana	2,437,300	18%
Wellpoint	1,012,400	7%
Member Health	924,100	7%
WellCare	849,700	6%
Total	**9,020,000**	**65%**

Note: The remaining 35 percent of the market is divided among at least 14 other companies. None has a market share of more than 4 percent.

Source: Centers for Medicare and Medicaid Services, *Medicare Prescription Drug Plans (PDPs) by Total Enrollment in Parent Organization*, available online at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp#TopOfPage. Data are as of May 1, 2006.

have, by far, the largest share of the total market for Part D plans, they have the greatest ability among all the private Part D insurers to secure the best drug prices. Yet, as our analysis demonstrates, their prices are much higher than those obtained by the Department of Veterans Affairs (VA), which negotiates for low drug prices on behalf of America's veterans.

We found that for all of the top 20 drugs prescribed to seniors, VA prices are substantially lower than the lowest prices charged by the largest Part D insurers. The median difference was 58 percent. In other words, for half of the 20 drugs, the lowest price charged by the largest Part D insurers is at least 58 percent higher. What's more, when we examined the full range of Part D plan prices, we discovered that the highest plan prices are considerably higher than their lowest prices.

In addition, to assess the effect that meaningful price negotiation would have on R&D, we analyzed the most recent annual filings to the Securities and Exchange Commission (SEC) by the seven largest U.S.-based pharmaceutical manufacturers. These filings report each company's R&D expenditures and profits, as well as what each company spends on marketing, advertising, and administration. We found that, on average, these drug companies spent more than twice as much on marketing, advertising, and administration as they did on R&D. Moreover, most of these drug companies retained profits that were larger than their R&D expenditures.

METHODOLOGY

In this report, Families USA compared the prices that the largest Part D insurers reported to the Centers for Medicare and Medicaid Services (CMS) in November 2006 for the 20 drugs most frequently prescribed to seniors. For those same drugs, we also compared Part D prices with the publicly reported prices negotiated through the VA.

CMS reports the largest Part D insurers as of May 1, 2006. The top five companies (UnitedHealthcare/PacifiCare, WellPoint, Humana, Member Health, and WellCare) account for nearly two-thirds (65 percent) of all beneficiaries enrolled in Part D plans. The remaining 35 percent of the market is divided among more than 14 other companies, and none of these other companies covers more than 4 percent of Part D enrollees.[1]

We obtained price data for Part D plans through Medicare's Prescription Drug Plan Finder, located online at www.medicare.gov. All Part D plan price data were collected through this Web site. Families USA evaluated prices for each of the plans offered by the top five insurers. (Each of the top five insurers offered more than one plan.) We tracked prices available through both mail order and retail pharmacies. Although we found that mail order prices were consistently lower across all of the plans, we report both low and high prices available through either mail order or retail pharmacies. Only drugs that were on a Part D plan's formulary—drugs for which the plan would have actively negotiated prices—were included in this analysis.

We obtained VA drug pricing information from the many price schedules that the VA negotiates, including the Federal Supply Schedule, the Restricted Federal Supply Schedule, the Big4 Pricing Schedule, and the National Contracts for the Department of Veterans Affairs. A more complete discussion of the study methodology and the VA pricing schedules is provided in the Technical Methodology on page 19.

KEY FINDINGS

- **The lowest Part D plan prices are significantly higher than the prices obtained by the VA (Table 2).**[2]
  - For each of the top 20 drugs prescribed to seniors, the lowest price charged by any of the top Part D insurers is higher than the lowest price secured by the VA.
  - Among those top 20 drugs, the median difference between the *lowest* Part D plan price and the *lowest* VA price is 58 percent.
- **The price differential between the lowest VA-negotiated price and the lowest price available from a Part D private plan is often substantial (Table 2). For example:**
  - For Zocor (20 mg), a lipid-lowering agent, the lowest VA price for a year's treatment is $127.44, while the lowest Part D plan price is $1,485.96—a difference of $1,358.52, or 1,066 percent.
  - For Protonix (40 mg), a gastrointestinal agent, the lowest VA price for a year's treatment is $214.52, while the lowest Part D plan price is $1,148.40—a difference of $933.88, or 435 percent.
  - For Fosamax (70 mg), an osteoporosis treatment, the lowest VA price for a year's treatment is $250.32, while the lowest Part D plan price is $763.56—a difference of 513.24, or 205 percent.
  - For Toprol XL (100 mg), a beta blocker, the lowest VA price for a year's treatment is $250.06, while the lowest Part D plan price is $395.52—a difference of $145.46 or 58 percent.
  - For Celebrex (200 mg), an anti-inflammatory, the lowest VA price for a year's treatment is $632.09, while the lowest Part D plan price is $946.44—a difference of $314.35, or 50 percent.
- **The median difference between the highest Part D plan price and the VA price is 101 percent.** In other words, for half of the 20 drugs, the highest price charged by a large Part D plan is at least twice as high as the lowest price secured by the VA (Table 2). Many Medicare beneficiaries are in drug plans in which they pay even higher prices.

Table 2

Prices for the Top 20 Drugs Prescribed to Seniors, Department of Veterans Affairs (VA) Versus Plans from Top Part D Insurers, November 2006

Drug Name	Strength	Dose Form	Lowest VA Price Per Year	Part D Plans		Percent Difference	
				Lowest Price Per Year	Highest Price Per Year	Lowest VA Price and Lowest Plan Price	Lowest VA Price and Highest Plan Price
Actonel	35 mg	tab	$ 372.24	$ 763.56	$ 902.64	105%	142%
Aricept	10 mg	tab	$1,058.69	$1,561.44	$ 1,795.56	47%	70%
Celebrex	200 mg	cap	$ 632.09	$ 946.44	$ 1,107.36	50%	75%
Fosamax	70 mg	tab	$ 250.32	$ 763.56	$ 902.64	205%	261%
furosemide	40 mg	tab	$ 7.81	$ 15.24	$ 54.96	95%	604%
Lipitor	10 mg	tab	$ 520.49	$ 785.40	$ 946.92	51%	82%
Lipitor	20 mg	tab	$ 782.44	$1,120.32	$ 1,340.52	43%	71%
metoprolol tartrate	50 mg	cap	$ 10.84	$ 16.20	$ 78.36	50%	623%
Nexium	40 mg	cap	$ 848.45	$1,433.16	$ 1,652.04	69%	95%
Norvasc	5 mg	tab	$ 315.84	$ 486.48	$ 592.56	54%	88%
Norvasc	10 mg	tab	$ 448.88	$ 667.56	$ 795.24	49%	77%
Plavix	75 mg	tab	$ 989.36	$1,323.24	$ 1,529.16	34%	55%
Prevacid	30 mg	cap DR	$ 332.71	$1,444.32	$ 1,647.00	334%	395%
Protonix	40 mg	tab	$ 214.52	$1,148.40	$ 1,333.20	435%	521%
Toprol XL	50 mg	tab	$ 167.22	$ 263.16	$ 342.60	57%	105%
Toprol XL	100 mg	tab	$ 250.06	$ 395.52	$ 490.56	58%	96%
Xalatan	0.005%	sol	$ 427.08	$ 582.96	$ 700.56	36%	64%
Zocor	20 mg	tab	$ 127.44	$1,485.96	$ 1,693.92	1,066%	1,229%
Zocor	40 mg	tab	$ 191.16	$1,485.96	$ 1,693.92	677%	786%
Zoloft	50 mg	tab	$ 465.91	$ 819.96	$ 1,254.24	76%	169%
Median Percent Difference						**58%**	**101%**

Note: Annual prices are calculated based on the price posted by the Part D plans and the Department of Veterans Affairs in November 2006. Prices listed for Zocor and Zoloft are for brand-name versions of these drugs. See endnote 2 for further discussion.

Sources: VA prices are from the VA pharmacy benefit manager (PBM) and the VA's list of national contracts. These prices were collected online through www.pbm.va.gov during the last week of November 2006. For each drug, the VA price shown is the lowest price for that drug on any one of several price schedules negotiated and maintained by the Department of Veterans Affairs (the Federal Supply Schedule, the Restricted Federal Supply Schedule, the Big4 pricing schedule, or the VA National Contracts).

Part D plan prices are from the Medicare Prescription Drug Plan Finder located online at www.medicare.gov, accessed the weeks of November 20 and 27, 2006.

Prices shown are the prices reported by the largest Part D insurers in Region 5 (DC/DE/MD), where we used zip code 20906 for the Washington/Baltimore metro area, and for Region 14 (OH), where we used zip code 45206 for Cincinnati. Prices presented here include both mail order and retail prices.

The drugs are the 20 drugs most frequently prescribed to seniors in the Pennsylvania PACE program in 2004.

- **Each of the seven largest U.S. publicly traded pharmaceutical companies spent substantially more on marketing, advertising, and administration than it spent on research and development (R&D) (Table 3).**
  - In 2005, five of the seven companies spent at least twice as much on marketing, advertising, and administration as they did on R&D.
  - On average, marketing, advertising, and administration comprised 32.0 percent of company revenues, while R&D represented 13.9 percent of company revenues.
- **Profits exceeded R&D expenditures for most of the large pharmaceutical companies (Table 3).**
  - Five of the seven companies generated more in profits than they spent on R&D in 2005.
  - On average, companies reported 17.4 percent of revenue as profits, whereas spending on R&D represented 13.9 percent of company revenues.

Table 3

2005 Financials for Top Seven U.S. Pharmaceutical Companies

Company	Revenue (Net Sales)*	Marketing, Advertising, and Administration*		Research and Development*		Profit (Net Income)*		Marketing, Advertising, and Administration Spending as a Multiple of R&D Spending
		Dollars	Percent	Dollars	Percent	Dollars	Percent	
Pfizer	$51,298	$16,997	33.1%	$7,442	14.5%	$8,085	15.8%	2.3
Johnson and Johnson	$50,514	$16,877	33.4%	$6,312	12.5%	$10,411	20.6%	2.7
Abbott Laboratories[1]	$22,338	$5,496	24.6%	$1,838	8.2%	$3,372	15.1%	3.0
Merck	$22,012	$7,156	32.5%	$3,848	17.5%	$4,631	21.0%	1.9
Bristol-Myers Squibb[2]	$19,380	$6,427	33.2%	$2,500	12.9%	$2,388	12.3%	2.6
Wyeth	$18,756	$6,118	32.6%	$2,749	14.7%	$3,656	19.5%	2.2
Eli Lilly	$14,645	$4,497	30.7%	$3,026	20.7%	$1,980	13.5%	1.5
Total	**$198,943**	**$63,568**		**$27,715**		**$34,523**		
Average			**32.0%**		**13.9%**		**17.4%**	**2.3**

* Dollars in millions

[1] Research and Development for Abbott Laboratories is the sum of two line items: "Research and Development" and "Acquired In-Process Research and Development."

[2] Marketing, Advertising, and Administration for Bristol-Myers Squibb is the sum of two line items: "Marketing, Selling, and Administrative" and "Advertising and Product Promotion"; the other companies report marketing and advertising spending together.

Source: The 2005 SEC form 10-K for each company.

DISCUSSION

A full year after the Medicare Part D drug program started, private plans have failed to achieve "the best discounts on drugs," as touted by former CMS Administrator Mark McClellan.[3] Part D plan prices are significantly higher than the prices available through the VA. For each of the 20 drugs most frequently prescribed to seniors, the lowest price available through any of the largest Part D insurers is higher than the lowest price negotiated by the VA. Moreover, because prices vary across plans, the actual prices that many beneficiaries are paying are likely to be substantially higher than the lowest prices listed in this report.

Why Lower Drug Prices Matter

How prices matter for beneficiaries

The low Part D prices we discuss in our Key Findings represent a best-case scenario: These are the lowest prices available for each of the 20 drugs from the largest Part D insurers. Looking only at the lowest prices available paints an unduly favorable picture of the Part D plans. Prices can range substantially higher, as shown in Table 2. In practice, a Medicare beneficiary who enrolls in a drug plan will probably be unable to obtain the lowest price on *all* the drugs he or she takes.

Drug prices matter to Part D beneficiaries because they determine when consumers meet their deductible and initial coverage limit. Moreover, when beneficiaries are in the coverage gap or "doughnut hole," they must pay the full price charged by the plan. Plans with lower drug prices can offer a better value to people in Medicare Part D.

To see what these price differences mean, consider Mrs. Brown, a hypothetical beneficiary who takes the five drugs most frequently used by seniors—Plavix (75 mg); Lipitor (10 mg); Fosamax (70 mg); Norvasc (5 mg); and Protonix (40 mg). How would she fare under the current program? Would she fare any better if Medicare obtained prices comparable to VA prices? The answer is a clear "yes."

Families USA queried Medicare's Prescription Drug Plan Finder to determine the least expensive Part D plan for Mrs. Brown. Using the same benefit plan structure, we then substituted the lowest VA price for the plan's base price for all five drugs to see how much she might save if private plans could get prices comparable to VA prices (Table 4).

Table 4

Potential Savings for Mrs. Brown: An Illustration

How much difference would it make to Mrs. Brown, a hypothetical Medicare beneficiary, if Part D plan prices were equal to the lowest VA prices? This example looks at the least expensive Part D plan (according to the Medicare Prescription Drug Plan Finder) for someone taking the five drugs most frequently prescribed to seniors. Using the same plan benefit structure, VA prices were substituted for the plan's reported base price for each drug. We then calculated when an enrollee would meet the deductible and reach the coverage limit using both the plan's prices and VA prices.

Monthly Out-of-Pocket Costs after Meeting Deductible and before Reaching Doughnut Hole

	Humana PDP Standard	Same Plan with Lowest VA Prices	Monthly Savings With VA Prices
Plavix (75 mg)	$27.57	$20.61	$6.96
Lipitor (10 mg)	$16.36	$10.84	$5.52
Fosamax (70 mg)	$15.91	$5.22	$10.70
Norvasc (5 mg)	$10.14	$6.58	$3.56
Protonix (40 mg)	$23.92	$4.47	$19.45
Total Monthly Costs (Mail Order)	**$93.90**	**$47.72**	**$46.18**

Monthly Out-of-Pocket Costs while in Doughnut Hole

	Humana PDP Standard	Same Plan with Lowest VA Prices	Monthly Savings With VA Prices
Plavix (75 mg)	$110.27	$82.45	$27.82
Lipitor (10 mg)	$65.45	$43.37	$22.08
Fosamax (70 mg)	$63.63	$20.86	$42.77
Norvasc (5 mg)	$40.54	$26.32	$14.22
Protonix (40 mg)	$95.70	$17.88	$77.82
Total Monthly Costs (Mail Order)	**$375.59**	**$190.88**	**$184.71**

Annual Costs, Humana PDP Standard Prices* versus VA Prices

	Humana PDP Standard	Same Plan with Lowest VA Prices	
Annual Premiums[1]	$77.28	$77.28	
Deductible	$250.00	$250.00	
Out-of-Pocket Spending after Deductible and before Reaching Doughnut Hole	$500.00	$500.00	
Out-of-Pocket Spending While in Doughnut Hole	$2,257.08	$40.56	
Total Annual Spending	$3,084.36	$867.84	
Annual Savings with VA Prices		**$2,216.52**	

Note: Numbers may not add due to rounding.

* In November 2006, the Medicare Prescription Drug Plan Finder recommended Humana PDP Standard as the least costly plan. Humana PDP Standard's monthly drug costs are based on 90-day mail order prices, the lowest prices available. The benefit for Humana PDP Standard includes a $250 deductible and 25 percent cost-sharing (based on the plan's price for the drugs) up to $2,250 in drug costs. After that, there is no coverage until an individual incurs $5,000 in total prescription drug costs during the year.

[1] Premiums presented here are for the Humana PDP Standard plan in Region 5 (MD/DE/DC). The premium in Region 14 (OH), also studied in this analysis, is significantly higher ($173.16 annually).

Compared to the lowest-priced plan that Medicare listed, Humana PDP Standard, Mrs. Brown would see significant savings if she could get prices comparable to the lowest VA prices. She would save $2,216.52 in annual out-of-pocket costs if the plan negotiated prices as effectively as the VA. If we look at the monthly cost for each drug (purchased by mail order) while Mrs. Brown is in the doughnut hole, we find that, *per month*, she would save $27.82 on Plavix, $22.08 on Lipitor, $42.77 on Fosamax, $14.22 on Norvasc, and $77.82 on Protonix. Overall, Mrs. Brown's total *monthly* cost while in the doughnut hole would be reduced from $375.59 to $190.88, a difference of $184.71.

Lower prices also help beneficiaries by slowing or even eliminating entry into the dreaded doughnut hole, in which beneficiaries must pay the full price of their drugs. In the above example, Mrs. Brown (in the Humana Standard plan with current 2006 prices) would meet her deductible in the first month of the year. She would enter the doughnut hole in June and pay full price for her drugs for the rest of the year. With VA prices, she would meet her deductible in February. She would not enter the doughnut hole until December, meaning she would have full drug coverage and limited out-of-pocket costs for most of the year.

MEDICARE PART D TERMS

The extent of beneficiaries' Part D drug coverage depends on their total drug spending during a calendar year. Individual plans can vary the structure of the benefit, but the basic benefit is as follows:

Deductible: A set dollar amount that must be paid *before drug coverage begins*. Beneficiaries pay 100 percent of their drug costs up to the deductible amount ($250 in 2006).

Initial Coverage Limit: Beneficiaries pay 25 percent of drug costs until their total drug costs reach the initial coverage limit ($2,250 in 2006). Once beneficiaries reach the initial coverage limit, their drug coverage ends, and they must pay for all medications out of pocket.

Doughnut Hole: A gap in drug coverage, colloquially known as the "doughnut hole." Beneficiaries pay 100 percent of their drugs costs while in the doughnut hole until their total drug costs reach a catastrophic threshold ($5,100 in 2006).

Catastrophic Coverage: After they have covered 100 percent of their costs in the "doughnut hole," beneficiaries receive catastrophic coverage and pay 5 percent of their remaining drug costs for the rest of the calendar year.

How prices matter for taxpayers

Part D drug prices matter to the public because taxpayers pay for most of the Part D program. Taxpayers pay for more than three-quarters of the cost of the drug benefit. First, they pay for the bulk of Part D premiums. Each plan's premium is largely determined by the cost of the drugs the plan covers. Every beneficiary who enrolls in the program pays 25.5 percent of the premium, and Medicare pays the remaining 74.5 percent.[4] Future increases in drug prices will translate into premium increases, raising the total cost of the program over time.

In addition, when beneficiaries with very high drug costs reach the catastrophic level of coverage (in 2006, when their total drug costs exceed $5,100 for the year), Medicare pays 80 percent of their additional costs (Part D plans pay 15 percent, and beneficiaries pay the remaining 5 percent).[5] Therefore, high drug prices for these beneficiaries have a direct cost to taxpayers.

Finally, the government pays directly for most or all of the Part D drugs for more than 9 million "dual eligibles" (beneficiaries who qualify for both Medicare and Medicaid) and other low-income beneficiaries who qualify for Part D's low-income assistance. These beneficiaries have limited financial resources and generally are sicker and take more prescription drugs than others in Medicare. Therefore, the law wisely protects them from unaffordable out-of-pocket costs. The high prices that plans charge for drugs are instead paid by the government and, ultimately, taxpayers.

Does the VA Keep Prices Down Only by Restricting Access?

Defenders of the current structure of the Medicare drug program contend that the reason the VA obtains such low prices is that the VA formulary—its list of covered drugs—includes fewer drugs and more tightly controls access than the formularies of most of the Part D plans. This assertion is misleading on three counts:

1. Access to drugs in the VA system is not limited to those drugs on the VA National Formulary. Those receiving care in the VA system who need drugs that are not on the VA formulary can obtain these drugs through a straightforward waiver process. In addition, at present, the VA National Formulary merely provides a minimum list of drugs that regional VA health systems *must* cover. Regional service networks currently have broad flexibility to expand access to drugs and, on average, cover 10 percent more drugs than are covered on the VA National Formulary.[6]

2. The VA negotiates low prices for all drugs, even those not on its formulary. For drugs not on the VA formulary, we found that VA prices were still lower than the lowest prices charged by Part D plans. The median price difference for drugs on the VA National Formulary was 58 percent. For drugs not on the VA National Formulary, the difference was 51 percent, still quite substantial (Table 5).
3. In some ways, the VA system actually gives broader access to prescription drugs than the formularies of Part D plans. Part D plans can require large copayments, impose quantity limits, and restrict access through prior-authorization requirements and utilization review. The VA charges only a small copayment per prescription and rarely imposes restrictions on the use of on-formulary drugs.[7]

Claims that the VA formulary achieves cost savings by unduly restricting access are simply unfounded. An overwhelming majority of VA physicians report that the formulary allows them to prescribe drugs that meet their patients' needs.[8] Patients also believe that their needs are being met: Access to drugs is an issue in less than one-half of one percent (0.4 percent) of veterans' complaints about the VA health system.[9]

Furthermore, Part D plans also have formularies. Eight of the 17 plans we studied in each of the regions excluded at least one of the top 20 drugs. However, for a large number of the drugs that *are* included in formularies, most plans place some type of restriction on use. On average, the Part D plans we studied covered only 12 of the 20 drugs without any restrictions, and they frequently required prior-authorization for formulary drugs. Looking ahead to 2007, these restrictions will tighten. All but two of the plans offered by the five large insurers we studied will either introduce new quantity limits or drop drugs from their formularies entirely in 2007.[10]

Finally, defenders of Part D plans sometimes claim that the VA prices are not comparable to Part D prices because the VA does not have a retail pharmacy network similar to those in Part D plans. While it is true that most VA drugs are delivered through mail order, every one of the lowest Part D prices cited in this study is also a mail-order price. Comparing VA prices to the lowest Part D mail order prices is entirely appropriate.

The VA pairs rational, cost-effective prescribing practices with the bargaining power of the government to achieve substantial cost savings. In contrast, Part D plans limit access without effectively controlling costs. A system of direct negotiation under Medicare would presumably differ in some ways from the VA in order to meet the particular needs of Medicare

Table 5

Price Differences between the Top Insurers' Plans and the VA Based on Placement on the VA National Formulary

Drugs on the VA National Formulary

Drug Name	Strength	Dose Form	Lowest VA Price Per Year	Part D Plans		Percent Difference	
				Lowest Price Per Year	Highest Price Per Year	Lowest VA Price and Lowest Plan Price	Lowest VA Price and Highest Plan Price
Actonel	35 mg	tab	$ 372.24	$ 763.56	$ 902.64	105%	142%
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Norvasc	5 mg	tab	$ 315.84	$ 486.48	$ 592.56	54%	88%
Norvasc	10 mg	tab	$ 448.88	$ 667.56	$ 795.24	49%	77%
Plavix	75 mg	tab	$ 989.36	$1,323.24	$1,529.16	34%	55%
Toprol XL	50 mg	tab	$ 167.22	$ 263.16	$ 342.60	57%	105%
Toprol XL	100 mg	tab	$ 250.06	$ 395.52	$ 490.56	58%	96%
Zocor	20 mg	tab	$ 127.44	$1,485.96	$1,693.92	1,066%	1,229%
Zocor	40 mg	tab	$ 191.16	$1,485.96	$1,693.92	677%	786%
Zoloft	50 mg	tab	$ 465.91	$ 819.96	$1,254.24	76%	169%
Median Percent Difference						**58%**	**142%**

Drugs Not on the VA National Formulary

Drug Name	Strength	Dose Form	Lowest VA Price Per Year	Part D Plans		Percent Difference	
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Lipitor	20 mg	tab	$ 782.44	$1,120.32	$1,340.52	43%	71%
Nexium	40 mg	cap	$ 848.45	$1,433.16	$1,652.04	69%	95%
Prevacid	30 mg	cap DR	$ 332.71	$1,444.32	$1,647.00	334%	395%
Protonix	40 mg	tab	$ 214.52	$1,148.40	$1,333.20	435%	521%
Xalatan	0.005%	sol	$ 427.08	$ 582.96	$ 700.56	36%	64%
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Note: Annual prices are calculated based on the price posted by the Part D plans and the Department of Veterans Affairs in November 2006. Prices listed for Zocor and Zoloft are for brand-name versions of these drugs. See endnote 2 for further discussion.

Sources: VA prices are from the VA pharmacy benefit manager (PBM) and the VA's list of national contracts. These prices were collected on-line through www.pbm.va.gov during the last week of November 2006. For each drug, the VA price shown is the lowest price for that drug on any one of several price schedules negotiated and maintained by the Department of Veterans Affairs (the Federal Supply Schedule, the Restricted Federal Supply Schedule, the Big4 pricing schedule, or the VA National Contracts).

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The drugs are the 20 drugs most frequently prescribed to seniors in the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) program in 2004.

beneficiaries. But if Medicare were able to use its leveraging power to negotiate on behalf of its millions of beneficiaries, it would likely be able to obtain prices that are much more in line with those secured for the millions of Americans covered through the VA.

Would Lower Drug Prices Jeopardize Research and Development?

Defenders of the current Part D drug pricing system claim that direct negotiation by Medicare would hurt pharmaceutical companies' R&D efforts, they believe that drug companies' revenues would fall so far that the industry would have to cut spending on R&D. When industry spending patterns and profits are explored, however, it becomes apparent that these claims simply are not true. We examined data from the seven publicly traded, U.S.-based research pharmaceutical companies that were among the Fortune 500's top 200 companies in 2005. These seven companies lead the industry in revenues, with combined revenues in 2005 of nearly $199 billion.[11]

Table 3, discussed in the Key Findings, shows that industry spending on marketing, advertising, and administration far exceeds spending on R&D. In most cases, R&D budgets were less than half of those dedicated to marketing, advertising, and administration. Profits also exceeded R&D spending for most companies.

What the pharmaceutical industry says and how it spends suggest two very different sets of priorities. The industry claims that innovation is its chief goal, while it spends a disproportionate and growing share on marketing. In fact, a recent Government Accountability Office (GAO) report found that, between 1997 and 2005, spending on direct-to-consumer advertising alone grew at twice the rate of R&D spending.[12]

R&D should be the lifeblood of future profits for the industry. Even if direct price negotiation by Medicare reduced industry revenues, companies could look elsewhere to make up the difference. The industry could absorb a reduction in revenues resulting from negotiation by Medicare without paring back R&D spending.

Is This the Best That the Part D Plans Can Do?

The prices that Part D plans charge people in Medicare for prescription drugs may not be the prices they negotiate with manufacturers. Part D plans may do much better—but we have no way of knowing for sure.

Each of the private plans participating in the Part D program negotiates separately with manufacturers to get discounts. The plans are required to pass along some of the discounts they negotiate to Medicare beneficiaries—*but the proportion of the discount that must be passed along is not specified*. While plans are required to report the prices they charge Medicare enrollees for particular drugs, they are not required to report the discounts they receive for specific drugs. We will never know what share of these discounts is passed on to people in Medicare and how much the plans retain themselves.

CONCLUSION

A year into the Medicare Part D program, price data show that Part D plans are failing to deliver on the promise that competition would bring prices down. The use of "market power," lauded by Medicare officials and the Administration, has not resulted in drug prices that are comparable to the low prices negotiated by the VA. At the same time, concerns that effective price negotiation by Medicare would somehow jeopardize the drug industry's R&D efforts are unfounded. Ample sources of alternative savings are available to the drug industry to weather any decline in revenues.

The law that established the Medicare prescription drug benefit, in prohibiting Medicare from using its negotiating clout on behalf of 43 million seniors and others in Medicare to obtain low drug prices, is costing seniors and taxpayers much more than it should. It is time to make the Medicare Part D program more cost-effective by eliminating the prohibition that prevents Medicare from bargaining for better prices.

ENDNOTES

[1] Centers for Medicare and Medicaid Services, *Medicare Prescription Drug Plans (PDPs) by Total Enrollment in Parent Organization*, available online at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp#TopOfPage. Data are as of May 1, 2006.

[2] Two of the drugs we studied, Zocor and Zoloft, became available in generic form during 2006. The prices we report are prices for the brand-name versions of Zocor and Zoloft. Including the generic prices for these drugs would not have changed the findings significantly. The lowest price for simvastatin (generic Zocor) 20 mg is 706 percent more expensive than the VA price for brand-name Zocor. The lowest price for simvastatin 40 mg is 317 percent more expensive than the VA price for brand-name Zocor. The lowest price for sertraline HCl (generic Zoloft) is 47 percent more expensive than the VA price for brand-name Zoloft. In addition, only two of the five companies studied included both generic simvastatin and generic sertraline HCl on their formularies.

[3] CMS Administrator Mark McClellan, Statement before the Senate Finance Committee, Hearings on the Medicare Prescription Drug Benefit, September 14, 2004.

[4] Section 1860D-13 of the Social Security Act, as added by the Medicare Modernization Act (Pub. L. No. 108-173).

[5] Section 1860D-15 of the Social Security Act, as added by the Medicare Modernization Act (Pub. L. No. 108-173).

[6] Institutes of Medicine, *Description and Analysis of the VA National Formulary* (Washington: IOM, June 2000). According to Families USA conversations with VA staff, the VA is considering changing this system starting in January 2007.

[7] Institute of Medicine, op. cit.

[8] Government Accountability Office, *VA Drug Formulary: Better Oversight Is Required, but Veterans Are Getting Needed Drugs*, GAO-01-183 (Washington: GAO, January 2001).

[9] Institute of Medicine, op. cit.

[10] Families USA analysis of 2007 prescription drug plan data for the top five insurers in regions 5 (MD, DE, DC) and 14 (OH) using online Medicare Prescription Drug Plan Finder available online at www.medicare.gov.

[11] In order of size (based on 2005 revenue), the companies included in this analysis are: Pfizer, Inc.; Johnson & Johnson; Merck & Co., Inc.; Abbott Laboratories; Bristol-Myer Squibb Company; Wyeth; and Eli Lilly and Company.

[12] Government Accountability Office, *Prescription Drugs: Improvements Needed in FDA's Oversight of Direct-to-Consumer Advertising,* GAO-07-54 (Washington: GAO, November 2006).

APPENDIX:

TECHNICAL METHODOLOGY

TECHNICAL METHODOLOGY

About Part D Plan Prices

All drug price data reflect 2006 prices for the plans offered by the largest Part D insurers. These data are from the Medicare Prescription Drug Plan Finder, located online at www.medicare.gov. Data were obtained the weeks of November 20 and 27, 2006.

Determining the High and Low Prices

We looked at each of the Part D plans operated by the five largest insurers (UnitedHealthcare/PacifiCare, WellPoint, Humana, Member Health, and WellCare) in two regions: Region 5, which covers Washington, D.C., Maryland, and Delaware; and Region 14, which covers Ohio. Nationally, these five insurers provide coverage for roughly two-thirds (65 percent) of all Part D beneficiaries in stand-alone drug plans. The Prescription Drug Plan Finder requires that all queries be based on a specific zip code. For Region 5, we used zip code 20906, a zip code for the Baltimore/Washington metropolitan area. For Region 14, we used zip code 45206, a zip code for the Cincinnati area.

For each of the plans offered by the top five insurers in each of those regions, Families USA recorded all prices, both mail order and retail, for each of the top 20 drugs prescribed to seniors. Mail order prices were consistently lower than retail prices across all of the plans, and this variation is reflected in tables that include both high and low prices. In our analysis, we included only drugs listed on a plan's formulary, based on the assumption that those are the drugs for which plans actively bargain for lower prices.

The prices we used were the prices posted by each plan for what drugs cost during the plan's coverage gap ("doughnut hole"), during which individuals must pay 100 percent of plan charges. These are the base prices that plans use to calculate when an individual meets the annual deductible and the initial coverage limit (the point at which the gap in coverage begins) and when the individual is eligible for catastrophic coverage. These prices should reflect the discounts that plans have been able to negotiate with drug manufacturers. These prices do reflect what most beneficiaries and taxpayers—who are subsidizing approximately three-quarters of program costs—are paying for the drugs these private plans provide.

In 2006, one plan, Humana PDP Complete, offers coverage through the coverage gap—the only cost to patients is a copayment. Because members of that plan do not pay full price while in the doughnut hole, we excluded it from the analysis.

About VA Prices

The Department of Veterans Affairs (VA) administers multiple drug pricing schedules on behalf of the federal government. The price schedules administered by the VA are the best representation of U.S. pharmaceutical prices achievable through government negotiations. For each pricing schedule, the negotiated prices are the prices at which a drug is available to any entity that is eligible to purchase from that schedule.

For the comparisons in this report, we examined the lowest publicly available price negotiated by the VA through these pricing schedules as examples of the types of drug prices that can be obtained when the government uses its purchasing clout in negotiations with manufacturers. Some drugs were listed on multiple schedules at different prices. We included the lowest available price for a supply (not exceeding 100 doses) in this report. Price data were obtained the week of November 27, 2006.

The Federal Supply Schedule: The Federal Supply Schedule (FSS) was established in 1949 to facilitate government supply purchases through pricing contracts. The VA is responsible for managing and awarding FSS contracts related to medical products and services, including prescription drugs. FSS prices are based on pricing data that manufacturers submit to the VA. The VA negotiates prices with the goal of obtaining prices that are equal to, or better than, Most Favored Commercial Customer (MFC) prices. However, on occasion, the Federal Supply Schedule price may be higher than the MFC price.

FSS prices are available to all government agencies, including the VA, the Department of Defense, the Bureau of Prisons, the Indian Health Service, the Public Health Service, and some state veterans' homes. Virtually all prescription drug manufacturers participate in the Federal Supply Schedule for all of their products.

Big4 Prices: The VA also administers the Big4 pricing program. This is a discount program that Congress established for the VA, the Department of Defense, the Coast Guard, and the Public Health Service. Under the Big4 program, a price cap is set on what manufacturers can charge purchasers; the price of a drug covered under the Big4 program cannot be more than 76 percent of the Non-Federal Average Manufacturer Price. In some instances, the VA obtains prices that are lower than required. Only brand-name drugs are covered under the Big4 pricing schedule. Sometimes, manufacturers, not wanting to negotiate and administer separate pricing contracts, offer the same pricing to the Big4 and the FSS. The groups with access to the Big4 pricing schedules can purchase from either the Federal Supply Schedule or the Big4 pricing schedule, choosing whichever one has the lower price.

Restricted Federal Supply Schedule: The Restricted Federal Supply Schedule (RFSS) is available to the VA and reflects additional price discounts that the VA has been able to obtain.

National Contract Prices: The VA further negotiates prices with manufacturers for the Veterans Health Administration and the 5 million or so veterans and dependents the program serves annually. National contracts are negotiated through competitive bidding. Low prices are generally obtained in exchange for inclusion on the VA formulary, the list of preferred drugs used by VA providers. National contract prices are generally lower than other pricing schedules, and only VA providers can purchase drugs from this price schedule. VA facilities and providers can purchase from any of these VA price lists, including purchasing non-formulary drugs when necessary.

Selection of the Drugs Used in the Analysis

The drugs analyzed for this report were the most frequently prescribed drugs in the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) program in fiscal year 2004. PACE is the largest and oldest outpatient prescription drug program for older Americans in the United States. In January 2004, there were 190,071 people enrolled in PACE, and PACE filled more than 9.4 million prescriptions during 2004. Because of the program's size and the abundance of claims data, it is commonly used to estimate prescription drug use among older Americans.

Using PACE claims data for 2004, Families USA identified the 20 drugs most frequently prescribed to seniors based on PACE claims volume. Vioxx, which was among the 20 most frequently prescribed drugs in 2004, was excluded from the list because the product was withdrawn from the market. In addition, three of the 20 drugs most frequently prescribed to seniors—Zocor 20 mg, Zocor 40 mg, and Zoloft 50 mg—became available in generic form in 2006. The prices reflected in this report are for brand-name versions of these drugs. Although generic versions of these drugs are now available, plans offered by three of the five insurers currently exclude some or all of these drugs from their formularies: Only two of the five companies studied included both generic simvastatin and generic sertraline HCl on their formularies. Further, prices for the generic versions are not substantially lower than their brand-name equivalents. The lowest price for simvastatin (generic Zocor) 20 mg is 706 percent more expensive than the VA price for brand-name Zocor. The lowest price for simvastatin 40 mg is 317 percent more expensive than the VA price for brand-name Zocor. The lowest price for sertraline HCl (generic Zoloft) is 47 percent more expensive than the VA price for brand-name Zoloft.

Pharmaceutical Industry Data

This report examines financial data from the seven publicly traded, U.S.-based research pharmaceutical companies that are among the Fortune 500's top 200 companies. These seven companies lead the industry in revenues, with combined total revenues of nearly $199 billion in fiscal year 2005. In order of size (based on 2005 revenue), the companies included in this report are: Pfizer Inc.; Johnson & Johnson; Merck & Co., Inc.; Abbott Laboratories; Bristol-Myers Squibb Company; Wyeth; and Eli Lilly and Company.

Families USA analyzed spending patterns reflected in annual reports (form 10-K) filed in fiscal year 2005 with the U.S. Securities and Exchange Commission (SEC) by each of the seven companies. For each company, we examined total revenues; marketing, advertising, and administration expenditures; research and development expenditures; and profits. These figures were computed as follows:

- **Total Revenue**: figures reported as "sales to customers," "net sales/sales," or "net revenues/revenues."
- **Marketing, Advertising, and Administration**: figures reported as "selling, informational and administrative expenses"; "selling, marketing and administrative expenses"; "selling, general and administrative"; or "marketing and administrative." One company, Bristol-Myers Squibb, reported advertising costs in a separate category, "advertising and product promotion." In this case, we computed the total marketing, advertising, and administration costs by adding the two reported figures.
- **Research and Development**: figures reported as "research and development expenses." Abbott laboratories also included a line item entitled "acquired in-process research and development." In this case, we computed the total research and development costs by adding the two reported figures.
- **Profit**: figures reported as either "net income" or "net earnings."

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