UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
MAJORITY STAFF
OCTOBER 2007

PRIVATE MEDICARE DRUG PLANS: HIGH EXPENSES AND LOW REBATES INCREASE THE COSTS OF MEDICARE DRUG COVERAGE

PREPARED FOR

CHAIRMAN HENRY A. WAXMAN

REP. BRUCE L. BRALEY

REP. JIM COOPER

REP. ELIJAH CUMMINGS

REP. BRIAN HIGGINS

REP. PAUL W. HODES

REP. PAUL E. KANJORSKI

REP. DENNIS J. KUCINICH

REP. BETTY MCCOLLUM

REP. CHRIS MURPHY

REP. EDOLPHUS TOWNS

REP. CHRIS VAN HOLLEN

REP. PETER WELCH

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Unlike traditional Medicare, which is run directly by the government, the new Medicare Part D prescription drug program depends on private insurers to provide drug coverage to Medicare beneficiaries. This reliance on private insurers has sparked a debate about the consequences of privatizing the delivery of Medicare services. Proponents, including President Bush, have argued that competition among private insurers will lead to "better coverage at more affordable prices." Opponents have questioned whether private companies can match the efficiency and negotiating power of traditional Medicare.

This debate over the design of Medicare Part D has been largely theoretical. The actual costs incurred by the private drug insurers and the drug prices they negotiate are proprietary and closely guarded. This has left Congress and the public without access to the information needed to assess the performance of private insurers and to compare their performance with traditional Medicare.

At the request of Chairman Waxman and Reps. Braley, Cooper, Cummings, Higgins, Hodes, Kanjorski, Kucinich, McCollum, Murphy, Towns, Van Hollen, and Welch, this report breaks new ground by analyzing proprietary cost and pricing data from the private insurers that operate the Medicare Part D program. The Committee obtained information on administrative expenses, sales costs, profits, and drug rebates from the 12 leading insurers offering Medicare prescription drug plans and Medicare Advantage drug plans. These 12 insurers provide Medicare drug benefits to over 18 million Medicare beneficiaries, almost 75% of the enrollees in Part D. The report is the first independent analysis to have access to this proprietary data about plan costs and drug prices.

The cost and pricing data obtained by the Committee reveal that use of private insurers to deliver Medicare drug coverage is driving up costs and producing only limited savings on drug prices. The report estimates that taxpayers and Medicare Part D beneficiaries could have saved almost $15 billion in 2007 if administrative expenses in the program were reduced to the level achieved by traditional Medicare and drug prices were lowered to Medicaid levels.

The report has five principal findings:

- **The Part D insurers have high administrative expenses.** The administrative expenses, sales costs, and profits of the private insurers offering Medicare Part D coverage will cost taxpayers and beneficiaries $180 per beneficiary in 2007. Taking into account the costs to the government of monitoring the private insurers, total administrative expenses, sales costs, and profits will reach $4.6 billion in 2007, with the profits of the Part D insurers alone accounting for $1 billion. The administrative expenses, sales costs, and profits of the privatized Part D program are almost six times higher than the administrative expenses of traditional Medicare. These high expenses do not appear to be due to one-time "start-up" costs because the total expenses increased from 2006 to 2007.

- **The Part D insurers have not negotiated significant drug manufacturer rebates.** The rebates negotiated from drug manufacturers by the private Part D insurers will reduce Medicare drug spending by 8.1% in 2007. In contrast, the Medicaid program receives rebates from drug manufacturers that reduce drug spending by 26%, over three times as much. The small size of the Medicare rebates and the transfer of low-income dual-eligible beneficiaries from Medicaid drug coverage to Medicare drug coverage will provide a $2.8 billion windfall to pharmaceutical manufacturers in 2007.

- **The Part D insurers receive rebates on drug purchases made by beneficiaries in coverage gaps.** The Medicare Modernization Act requires that private insurers give Medicare beneficiaries "access to their negotiated prices," including "all discounts, … rebates, [or] other price concessions." When the Part D insurers obtain rebates, however, they do not pass them through to beneficiaries by reducing drug prices in coverage gaps like the "donut hole." Instead, the dollars flow in the opposite direction: the private insurers receive rebates from the drug manufacturers on purchases paid out-of-pocket by beneficiaries. In 2007, the Part D insurers are expected to receive $1.0 billion in drug rebates from transactions in which beneficiaries in coverage gaps pay 100% of the drug costs.

- **The Part D insurers have established drug pricing formulas that leave beneficiaries and taxpayers vulnerable to price increases.** In almost all cases, the private insurers use pricing formulas that pay pharmacies the drug manufacturers' full list prices minus a fixed percentage and a small dispensing fee. These formulas have resulted in drug prices that are generally no lower than those already available through discount pharmacies and on-line drugstores, while leaving beneficiaries and taxpayers vulnerable to repeated increases in list prices by the drug manufacturers.

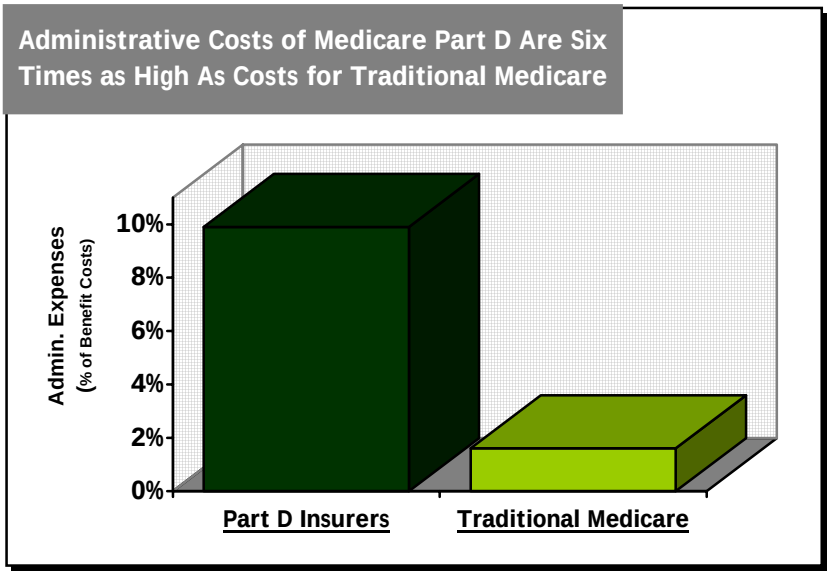
- **The Part D insurers have a mixed record in promoting the use of generic drugs.** In 2007, 59% of prescriptions filled by Medicare Part D will be filled with generic drugs. This level of use of generic drugs compares favorably with Medicaid, which fills 54% of prescriptions with generic drugs. It does not compare favorably with the experience of the Department of Veterans Affairs, which fills 68% of prescriptions with generic drugs.

High Administrative Costs, Sales Expenses, and Profits

The administrative costs, sales expenses, and profits of the private Part D insurers result in significant costs to taxpayers and Medicare beneficiaries. In 2007, the Part D insurers will incur $4.3 billion in administrative costs, sales expenses, and profits, an average of $180 per beneficiary enrolled in Medicare Part D. One Part D insurer reported administrative costs, sales expenses, and profits of $325 per beneficiary for one of its plans in 2007. Many reported administrative costs, sales expenses, and profits in excess of $200 per beneficiary.

In addition to the insurers' administrative costs, sales expenses, and profits of $4.3 billion, the Centers for Medicare and Medicaid Services (CMS) spends an additional $300 million administering the Part D program. Taking these added costs into account,

the total administrative costs, sales expenses, and profits of the program will be $4.6 billion in 2007. These administrative costs, sales expenses, and profits account for 9.8% of the total costs of Medicare Part D.



These administrative expenses, sales costs, and profits are well above the administrative expenses for other parts of the Medicare program. Traditional Medicare administrative expenses under Part A (hospital care) and Part B (outpatient care) account for 1.7% of total Part D costs. The administrative expenses, sales costs, and profits of the privatized Medicare Part D program are almost six times higher than administrative expenses of the traditional Medicare program. Reducing the administrative expenses, sales costs, and profits of the Part D program to the level of traditional Medicare would save taxpayers and beneficiaries $3.9 billion in 2007.

The Medicare Part D administrative expenses, sales costs, and profits are also over three times higher than the administrative expenses of a large state provider of prescription drugs to seniors and almost twice as high as the expenses incurred by large private pharmacy benefit managers in delivering drug benefits to private sector clients.

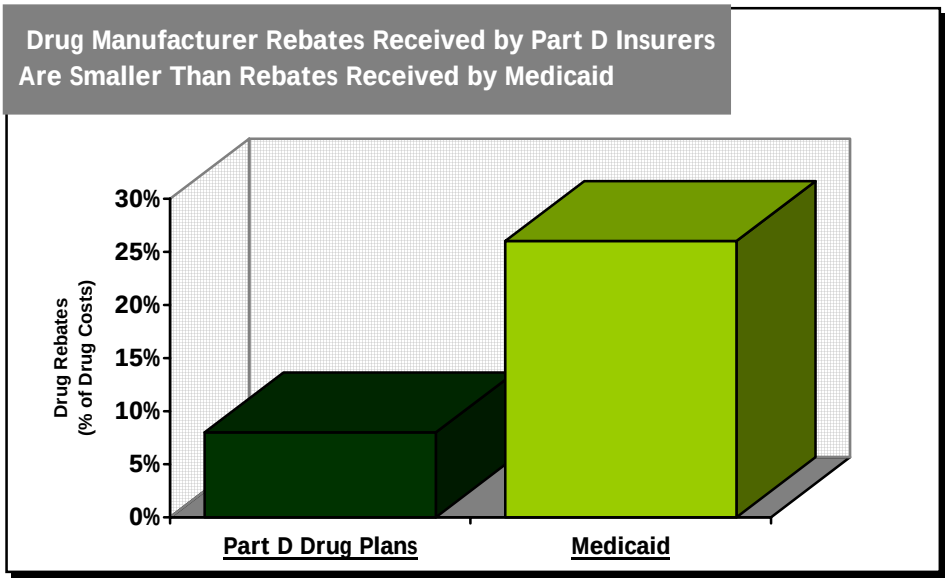
The high administrative expenses, sales costs, and profits of the Part D insurers do not appear to be attributable to one-time "start-up" expenses incurred during 2006, the first year of Part D coverage. The average administrative expenses, sales costs, and profits of the insurers increased by 15% in 2007, rising from $156 per beneficiary in 2006 to $180 per beneficiary in 2007.

Low Drug Rebates

In total, the manufacturer rebates negotiated by the Part D insurers will reduce drug spending by 8.1% in 2007. These rebates are smaller than those received by other government programs. Manufacturer rebates reduce Medicaid drug spending by 26%, over three times as much. Although not directly comparable, the Department of Veterans Affairs (VA) negotiates average manufacturer drug discounts of 50%. If the Part D

program obtained drug manufacturer rebates that were as large as the Medicaid rebates, drug costs for taxpayers and beneficiaries would be reduced by $10.7 billion in 2007.

Both Medicaid and the VA obtain rebates or discounts from both manufacturers of brand-name drugs and manufacturers of generic drugs. The Part D insurers have, in almost all cases, been able to obtain these rebates only from manufacturers of brand-name drugs. In total, the Part D insurers examined in this report received rebates on only 637 different drugs, 27% of the 2,370 drugs used by Medicare Part D beneficiaries. The average Part D insurer received rebates on only 210 drugs, just 8.6% of the 2,370 different drug products used by beneficiaries. Of the 100 drugs with the highest expenditures under Medicare Part D, there were 18 drugs for which none of the insurers negotiated any rebates, including several brand-name drugs.



The small size of the rebates has resulted in a significant windfall for pharmaceutical manufacturers, particularly for drugs that are sold to dual eligible beneficiaries: individuals who are enrolled in both Medicaid and Medicare. Prior to January 1, 2006, there were 6.2 million Medicare beneficiaries who received their drug coverage through the Medicaid program. For the drugs purchased by these beneficiaries, the manufacturers provided significant rebates. After January 1, 2006, these dual eligible beneficiaries were switched to Medicare Part D coverage. Because they are now providing much smaller rebates on the drugs used by these Part D beneficiaries, drug manufacturers are receiving a windfall in reduced rebates worth an estimated $2.8 billion in 2007.

Drug Rebates in Coverage Gaps

The Medicare Modernization Act requires that Medicare beneficiaries have "access to negotiated prices," including "all discounts, direct or indirect subsidies, rebates, other price concessions, or direct or indirect remunerations." This provision is intended to ensure that even when beneficiaries are in coverage gaps, they are able to benefit from pricing discounts or rebates negotiated by the Part D insurers.

Despite the statutory mandate, the private insurers are not using the rebates they receive to reduce drug prices for Part D beneficiaries at the pharmacy. Instead, the insurers are retaining these rebates even when the beneficiaries are in coverage gaps and are paying the full cost of the drugs themselves. The total value of the rebates that the Part D insurers receive on purchases made by beneficiaries in coverage gaps is large. In 2007, the Part D insurers are expected to receive $1.0 billion in rebates on drug purchases paid for out-of-pocket by beneficiaries.

The Part D insurers claim that they use these excess rebates received from drug manufacturers to reduce drug plan premiums, providing an actuarially equivalent reduction in premiums. Premium reductions, however, provide no savings at the pharmacy counter and result in an indirect subsidy from beneficiaries with high out-of-pocket drug expenditures to beneficiaries with no or low out-of-pocket expenditures. Several of the Part D insurers conceded in interviews that they retain a portion of these rebate payments as profits.

Increases in Drug Manufacturer List Prices

With only two exceptions, the Part D insurers have established drug pricing formulas that pay pharmacies the manufacturers' published "Average Wholesale Prices," which are the manufacturers' list prices, minus a fixed percentage (on average 15%), plus a small dispensing fee (on average $2.10 per prescription). These pricing formulas result in pharmacy prices that are about the same as the prices charged by discount pharmacies like Costco, Wal-Mart, or Drugstore.com.

One effect of these pricing formulas is that they leave beneficiaries and taxpayers vulnerable to increases in drug manufacturer list prices, which are passed on as price increases at the pharmacy counter. Since the Part D program went into effect in January 2006, the average list price for the 25 most popular drugs used by Part D beneficiaries has increased by 8.9%, almost twice as fast as the overall inflation rate. Under the pricing formulas negotiated by the Part D insurers, beneficiaries in coverage gaps pay these price increases out-of-pocket. Beneficiaries enrolled in plans that set copay levels as a percentage of the pharmacy price also pay higher copays. Taxpayers are vulnerable to the increases in list prices because the Medicare program pays the full cost of drugs used by low-income Part D beneficiaries and 80% of the costs of drugs used by beneficiaries who receive catastrophic coverage.

Use of Generic Drugs

In 2007, 59% of prescriptions for Medicare Part D beneficiaries will be filled with generic drugs. The level of generic drug use in Medicare Part D is higher than the level of generic drug use in Medicaid, which fills 54% of prescriptions with generic drugs. The level of generic drug use in Medicare Part D is significantly lower than the level of generic drug use achieved by the VA, which fills 68% of prescriptions with generic drugs.

I. INTRODUCTION

The legislation creating the Medicare Part D drug program was signed into law by President Bush in November 2003. The program went into effect on January 1, 2006, and is now in its second year of operation. In 2007, the cost of the Medicare Part D program will be almost $47 billion, taking into account both taxpayer subsidies and beneficiary premiums. In addition, Medicare Part D beneficiaries will pay $17.5 billion in additional out-of-pocket drug costs and copays. Over the next decade, Medicare Part D coverage is estimated to cost $925 billion.[1]

The new Medicare Part D drug program differs significantly from Medicare Part A, which covers hospital expenses, and Medicare Part B, which covers outpatient care. Unlike Part A and Part B, the Part D program is not administered directly through the federal government. Instead, it has been privatized, with private insurers contracting with Medicare to deliver Part D coverage. In addition, plans are not standardized. Instead, each insurer offers multiple plans with different premiums, copays, and formularies.

Approximately 24.1 million beneficiaries are enrolled in Medicare Part D drug plans.[2] Almost 17 million of these beneficiaries are enrolled in stand-alone prescription drug plans (PDPs). The remainder are enrolled in Medicare Advantage plans with prescription drug benefits (MA-PDs).

A. The Structure of the Medicare Part D Program

The private insurers offering Medicare Part D plans are subsidized by the Medicare program, with payments determined by a bidding process. Each Medicare Part D insurer submits a bid to the Centers for Medicare and Medicaid Services containing the estimated costs of providing a "standard" Medicare benefit. These bids take into account factors such as anticipated enrollment and drug use, plan administrative and sales costs, drug prices, estimated rebates and discounts, and plan profits.

Under the standard 2007 benefit plan, beneficiaries pay the full cost for the first $265 worth of drugs used and then receive a 75% subsidy until their drug spending reaches $2,400. At this point, beneficiaries enter a coverage gap or "donut hole": subsidies are eliminated, and the beneficiaries pay both their premiums and the full cost of their drugs until their drug spending reaches $5,100, which is the starting point for catastrophic

---

[1] Department of Health and Human Services, 2007 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds (2007). These costs include the direct costs of enrollment of beneficiaries in Medicare Prescription Drug Plans (PDPs) and Medicare Advantage Drug Plans (MA-PDs). It does not include the cost of subsidies offered to employers to provide retiree drug coverage.

[2] Centers for Medicare and Medicaid Services, *Medicare Advantage, Cost, PACE Demo, and Prescription Drug Plan Contract Report – Monthly Summary Report* (July 2007). An additional ten million beneficiaries are enrolled in employer or union retiree health plans that offer "creditable" Part D coverage. These plans receive subsidies from the Medicare program for providing this private-sector coverage. These employer and union plans were not included in this analysis.

coverage. Beneficiaries then pay only 5% of the cost of all additional drug purchases for the year.

Although the actual Medicare drug plans offered by the private insurers can vary considerably (with different copays, premiums, and formulary structures), the Part D insurers' bids for the standard benefit form the basis of the Medicare subsidy received by each plan. For each beneficiary, CMS provides approved plans with a subsidy equal to approximately 75% of the cost of the average standard benefit. The remaining plan costs are paid by beneficiaries as monthly premiums.

In addition to subsidizing premiums, the Medicare program also provides significant additional payments to the Part D insurers. Medicare pays for the premiums and out-of-pocket drug costs of low-income beneficiaries. In addition, Medicare reimburses the Part D insurers for 80% of the drug expenditures of beneficiaries who have spent more than $5,100 on prescription drugs and have entered into the catastrophic coverage portion of the benefit.

B. The Debate over the Reliance on Private Insurers

The use of private insurance companies to provide the Medicare Part D benefit has been the subject of a vigorous debate. This debate, which started during congressional consideration of the Medicare drug law, continues today.

On one side, President Bush, other senior administration officials, Republican leaders in Congress, and the insurance and pharmaceutical industries argue that competition among many private insurers is the most effective way to keep prices low for seniors and taxpayers. In October 2003, as Congress was debating the Medicare legislation, the President claimed:

> The best way to provide our seniors with modern medicine, including prescription drug coverage … is to give them better choices under Medicare. If seniors have choices, health plans will compete for their business by offering better coverage at more affordable prices.[3]

Secretary of Health and Human Services Tommy Thompson promised:

> Health insurance companies are going to get into this market. … The pharmaceutical benefit managers who will be taking over purchasing the drugs are going to be able to purchase in bulk with the pharmaceutical companies and hold down prices.[4]

Republicans on the House Ways and Means Committee claimed that the Part D structure "will allow competitive forces in the private market to generate the best savings for

---

[3] The White House, President Calls on Congress to Complete Work on Medicare Bill (Oct. 29, 2003).

[4] *The Big Story with John Gibson*, Fox News Network (Nov. 26, 2003).

seniors."[5] Senate Majority Leader Bill Frist asserted that "competition through the private sector, through bulk purchasing and negotiation, is a more effective means to hold down prices."[6]

As the Bush Administration implemented the new Medicare Part D program, these promises of low drug prices were reiterated. In September 2004, Medicare Administrator Mark McClellan claimed that the private insurers would be able to obtain "the best" prices for seniors. He stated:

> Our approach is expected to provide the best discounts on drugs, discounts as good or better than could be achieved through direct government negotiation.[7]

Proponents of the Medicare Part D program continued to make such claims after the program went into effect. In February 2006, Dr. McClellan claimed that "the drug plans are negotiating aggressive discounts and rebates that are being passed along to beneficiaries and taxpayers."[8] In June 2006, CMS claimed:

> Savings under Part D are driven by the price discounts negotiated by the plans, which are as large as, and in many cases, substantially better than "third party" negotiated prices.[9]

Pharmaceutical and insurance industry representatives have consistently made similar assertions. According to representatives of the drug industry, "low Part D bids have largely been driven by plans' ability to secure substantial price discounts and rebates on drugs furnished to Medicare beneficiaries."[10] The industry organization representing many Part D insurers has claimed that the insurers are providing "deeper than expected discounts"[11] and "tremendous savings."[12]

On the other side of the debate, public health groups, some independent health experts, and Democratic members of Congress have raised questions about the cost and effectiveness of the private Part D insurers. Analyses of Medicare drug plan prices in 2006 indicated that the Part D insurers were failing to provide seniors with significant price discounts at the pharmacy counter and were unable to control rapid increases in

---

[5] Committee on Ways and Means, Hearing on Negotiating Lower Prices for America's Seniors, 108th Cong. (Dec. 11, 2003).

[6] *Does Medicare or Private Insurance Do a Better Job of Controlling Health Care Costs?,* The New York Times (Nov. 27, 2003).

[7] Testimony of Dr. Mark McClellan, Senate Finance Committee, *Hearing on The Medicare Prescription Drug Benefit,* 109th Cong. (Sept. 14, 2005).

[8] *Medicare Profits Raise Flags*, Knight Ridder Newspapers (Feb. 3, 2006).

[9] Centers for Medicare and Medicaid Services, Large Negotiated Price Discounts Continue in Medicare Part D (June 2006).

[10] Biotechnology Industry Organization, Medicare Part D Plans Deliver Significant Savings on Innovative Breakthrough Medicines (2007).

[11] Pharmaceutical Care Management Association (PCMA), *PCMA Statement on U.S. House Approval of H.R. 4* (Jan. 4, 2007).

[12] Pharmaceutical Care Management Association (PCMA), Beneficiaries in Part D Enjoying Broad Savings and Broad Access on Their Prescription Drugs (May 2, 2007).

drug costs.[13] Additional increases in drug plan premiums beginning in January 2007 raised further questions about whether the privatized structure of the Medicare Part D program was providing significant savings for taxpayers and beneficiaries.[14]

II. OBJECTIVE AND METHODOLOGY

The debate over the effect of privatizing the delivery of Medicare Part D coverage has been largely theoretical. Answering the questions about the performance of the private Part D insurers requires access to the actual cost and pricing data of the insurers. These data are propriety and closely guarded. This has left Congress and the public without access to the information needed to assess the performance of Part D private insurers and to compare their performance with traditional Medicare.

At the request of Rep. Waxman and Reps. Braley, Cooper, Cummings, Higgins, Hodes, Kanjorski, Kucinich, McCollum, Murphy, Towns, Van Hollen, and Welch, this report seeks to advance the discussion about the performance of the private Part D insurers by examining proprietary data from the insurers about their administrative expenses, sales costs, and profits, as well as their ability to obtain manufacturer drug price discounts and rebates. This report is the first independent report to have access to real data about plan costs and drug prices.

The report is based on information provided to the House Committee on Oversight and Government Reform by the Medicare Part D insurers. On February 9, 2007, the Committee requested detailed financial and actuarial information from the 12 leading firms providing Medicare Part D prescription drug benefits.[15] The 12 insurers surveyed by the Committee are the leading providers of stand-alone Medicare prescription drug plans (PDPs) and Medicare Advantage drug plans (MA-PDs). Combined, these companies provide Part D benefits to over 18 million Part D beneficiaries, 75% of all current MA and PDP beneficiaries.[16]

The Committee requested information from the 12 insurers on "Medicare drug plan profits; Medicare drug plan administrative expenses; negotiated price discounts, rebates, and other price concessions obtained from drug manufacturers and pharmacies by Medicare drug plans; and the extent to which, and the methods by which, these discounts,

---

[13] See, e.g., Minority Staff, Special Investigations Division, House Committee on Government Reform, *New Medicare Drug Plans Fail to Provide Meaningful Drug Price Discounts* (Nov. 2005); Families USA, *No Bargain: Medicare Drug Plans Deliver High Prices* (Jan. 2007); Minority Staff, Special Investigations Division, House Committee on Government Reform, *Medicare Drug Plan Prices Are Increasing Rapidly* (Nov. 2005).

[14] *See* Letter from Rep. Henry A. Waxman to HHS Secretary Michael O. Leavitt (Oct. 12, 2006).

[15] The 12 insurers are Aetna, Caremark (now CVS/Caremark), Coventry, Highmark, Humana, Kaiser, Medco, Memberhealth, United, Universal American, Wellcare, and Wellpoint.

[16] Centers for Medicare and Medicaid Services, *Medicare Advantage Plans with Medicare Prescription Drug Coverage (MA-PDs) by Total Enrollment in Parent Organization* (April 2006); Centers for Medicare and Medicaid Services, *Medicare Prescription Drug Plans (PDPs) by Total Enrollment in Parent Organization* (April 2006).

rebates, and other price concessions obtained by Medicare drug plans are passed on to beneficiaries."[17] The Committee obtained complete information from all 12 insurers. All 12 insurers cooperated with the Committee request, with 11 of the 12 providing the information voluntarily. Because of its proprietary nature, the information is not being used in this report in a manner that would allow identification of individual drug insurers.

For each insurer, the Committee received bid forms submitted to CMS for 2006 and 2007. These bids contain the insurers' estimates of average administrative expenses, drug costs, and profits for each beneficiary enrolled in the plan. The bids are used by CMS to determine subsidy levels and to establish plan premiums for Part D beneficiaries. The bid forms for 2006 were submitted to CMS on June 5, 2005, and the bid forms for 2007 were submitted on June 5, 2006. The bid forms represent the insurers' own estimates of plan costs, drug utilization, and plan enrollment

In analyzing the information in the bid forms, the Committee staff initially examined the bid data for 400 separate drug plans offered by the 12 drug insurers. These plans were the 250 most popular PDPs and the 150 most popular MA-PDs, based on 2006 enrollment. Following this initial selection, Part D plans that were available in 2006 but were no longer available in 2007 were excluded from the sample, resulting in a final sample size of 318 plans comprising 215 PDP plans and 103 MA-PD plans. The plans that are included in the analysis provide benefits to approximately 12.5 million Part D beneficiaries, over half of all Medicare beneficiaries that are presently enrolled in PDP or MA-PD plans.

In addition to the bid data, the Committee also received the drug rebate and discount reports each insurer submitted to CMS for the first and second quarters of 2006.[18] This information is submitted in aggregate for all Part D plans offered by the insurer, not for each individual plan. For drug rebates, the insurers report the total value of rebates received for each individual drug. For other drug discounts and price concessions, the insurers do not report information for each individual drug. Instead, they report only aggregate discounts received from each drug manufacturer. This information was used in this report to assess the range and scope of the rebates and discounts received by the Part D insurers.

In addition to analyzing the information obtained from the Part D insurers, Committee staff spoke with representatives of the Part D insurers; obtained data on drug utilization by Medicare Part D beneficiaries from the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) program, the largest state drug assistance program for seniors in the nation, which subsidizes Part D premiums and copayments for approximately 350,000 Pennsylvania seniors;[19] and contacted independent experts on the

---

[17] Letter from Chairman Waxman to Medicare Part D Insurers (Feb. 9, 2007) (online at http://oversight.house.gov/story.asp?ID=1169).

[18] These two quarters of rebate data were the only data available when the Committee made its request on February 9, 2007. The first quarter 2006 data was submitted on September 30, 2006, and the second quarter data was submitted on December 31, 2006.

[19] Pennsylvania Department of Aging, PACE Assistance Contract for the Elderly 2006 Annual Report (2006).

Medicare program and the pharmacy benefit management industry, including experts with the Government Accountability Office and the Congressional Research Service.

All results in the report that describe average plan administrative expenses, sales costs, profits, or rebates represent enrollment-weighted averages, normalized to reflect the national ratio of beneficiaries in PDP and MA-PD plans.

III. FINDINGS

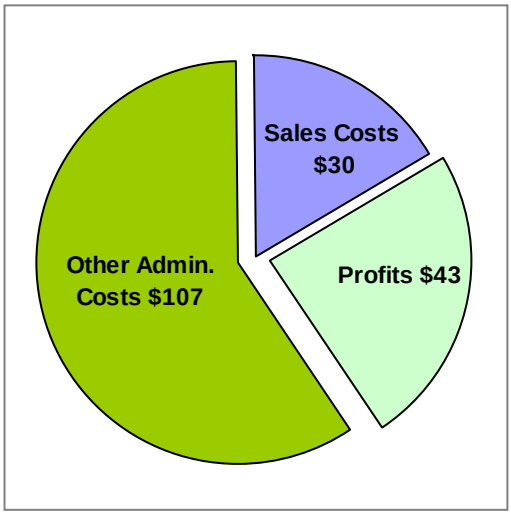
A. Administrative Costs, Sales Expenses, and Profits

1. Costs to Taxpayers and Beneficiaries

The administrative expenses, sales costs, and profits of the Part D insurers result in significant costs to taxpayers and beneficiaries.[20] This year, the average administrative expenses, sales costs, and profits of the Part D insurers are $180 per beneficiary. There are currently 24.1 million beneficiaries enrolled in Medicare Part D. For 2007, the total administrative costs, sales expenses, and profits of the Part D insurers will be $4.3 billion.

In 2007, the profits of the Part D insurers will average $43 per beneficiary; the sales costs will average $30 per beneficiary; and the other administrative expenses will average $107 per beneficiary. Figure 1. The aggregate profits of the Part D insurers will be $1.0 billion; the aggregate sales costs will be $720 million; and the aggregate other administrative expenses will be $2.6 billion.

FIGURE 1: Administrative Costs, Sales Expenses, and Profits for Medicare Part D Plans Cost $180 Per Enrollee in 2007



[20] These administrative costs, sales expenses, and profits are reported to CMS on the bid forms under the general category of "non-pharmacy expenses."

Administrative expenses, sales costs, and profits vary widely among individual plans. The plan with the lowest administrative costs in 2007 reported administrative expenses, sales costs, and profits of $71 per beneficiary. The plan with the highest costs reported administrative expenses, sales costs, and profits of $325 per beneficiary. Overall, 25% of the plans reported administrative expenses, sales costs, and profits of over $200 per beneficiary, and 8% reported costs of over $300 per beneficiary.

In addition to the administrative expenses, sales costs, and profits of the Part D insurers, CMS expends an additional $300 million in costs in administering Part D.[21] These costs are incurred as CMS conducts basic fiscal analysis, program oversight, beneficiary enrollment, and other responsibilities under Part D. These additional costs raise the total administrative costs of the Part D program to $4.6 billion.

The administrative expenses, sales costs, and profits consume a significant portion of the Part D benefit. Taking into account the premiums paid by beneficiaries and taxpayers, the additional federal payments for low-income beneficiaries and catastrophic coverage, and CMS's administrative costs, the Medicare Part D program will cost $46.8 billion in 2007. Of this amount, 9.8% ($4.6 billion) will be consumed by the administrative expenses, sales costs, and profits of the Part D insurers and CMS.

2. Comparison to Other Government Health Care Programs

The administrative expenses, sales costs, and profits of the privatized Part D program are significantly higher than the administrative expenses of other parts of Medicare. Medicare administrative expenses under Parts A and B account for 1.7% of total benefit costs.[22] The administrative expenses, sales costs, and profits of Medicare Part D are almost six times higher the administrative expenses of traditional Medicare. Figure 2.

The Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) program is the nation's largest state-level drug assistance program for seniors. Administrative expenses in the PACE program average only 3.0% of benefit costs.[23] The administrative expenses, sales costs, and profits of the Medicare Part D program are more than three times the administrative expenses of the PACE program.

The high administrative expenses, sales costs, and profits of the Medicare Part D program result in billions of dollars in excess expenditures by taxpayers and beneficiaries. If these expenses could be reduced to the same level as administrative expenses for traditional Medicare, the savings would be $3.9 billion in 2007.

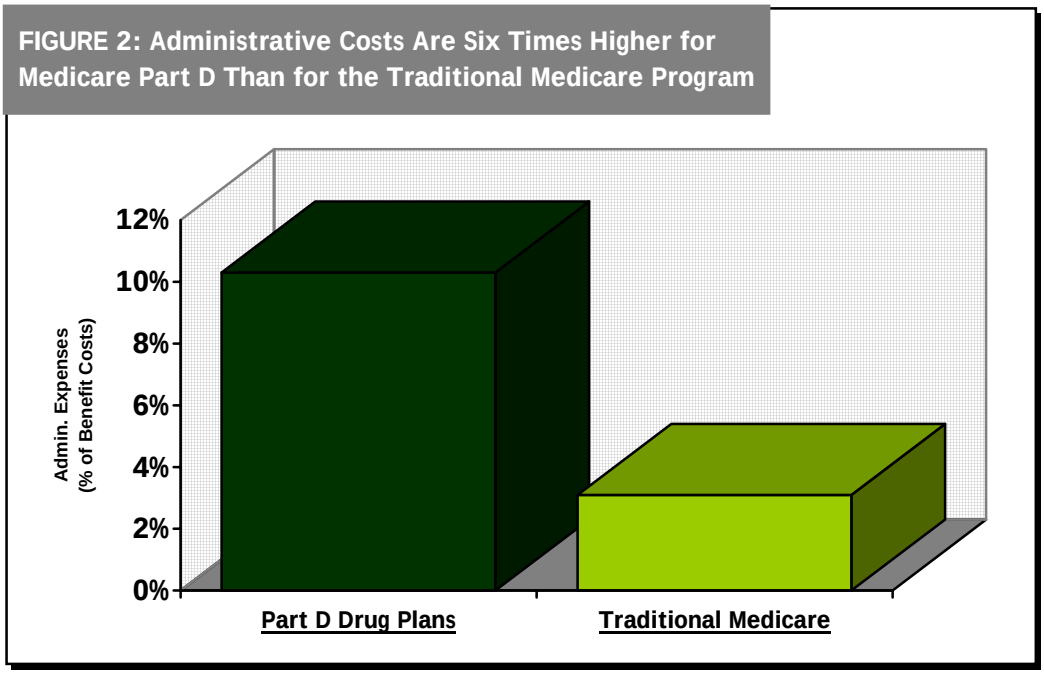
---

[21] Department of Health and Human Services, 2007 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds (2007).

[22] Department of Health and Human Services, 2007 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds (2007) at 5. In 2006, total benefit costs for Medicare Parts A and B were $360.9 billion, and administrative expenses were $6.0 billion.

[23] Pennsylvania Department of Aging, PACE Assistance Contract for the Elderly Annual Reports (2003-2006).

FIGURE 2: Administrative Costs Are Six Times Higher for Medicare Part D Than for the Traditional Medicare Program



3. Comparison to Private Sector Health Care Programs

The administrative expenses, sales costs, and profits of the Part D insurers are also higher than the administrative expenses, sales costs, and profits reported by private-sector pharmacy benefit managers. The three largest publicly owned pharmacy benefit managers are ExpressScripts, Medco, and CVS/Caremark. As part of their annual financial reports, these companies report the number of prescriptions that they fill and their total administrative expenses, sales costs, and profits for each year. For the three-year period from 2004 through 2006, the three companies filled a total of 4.5 billion prescriptions and reported average administrative expenses, sales costs, and profits of $11.1 billion, an average of $2.48 per prescription.[24]

In comparison, the average administrative expenses, sales costs, and profits of the Part D insurers in 2007 will be $5.08 per prescription.[25] On a per-prescription basis, the administrative expenses, sales costs, and profits of the Part D insurers are over twice as high as the administrative expenses, sales costs, and profits of the large private-sector pharmacy benefit managers. Figure 3.

4. Changes in Annual Administrative Expenses

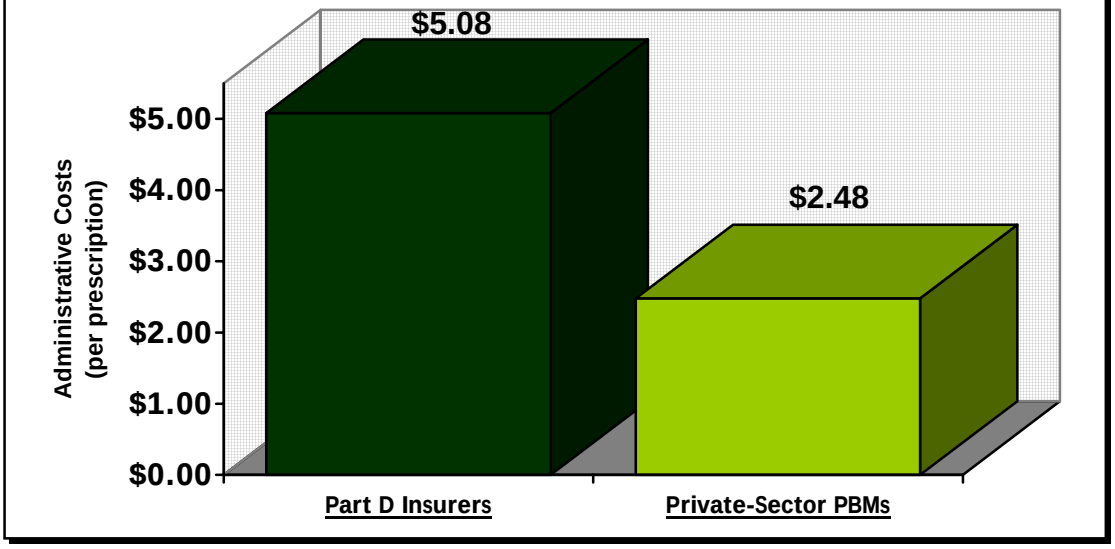
The high administrative expenses, sales costs, and profits of the Part D program do not appear to be attributable to one-time "start-up" expenses incurred during 2006, the first year of Part D coverage. In fact, these costs were lower in 2006 than in 2007. One

[24] ExpressScripts, Caremark, and Medco, *Annual Financial Reports* (2004-2006).

[25] The average administrative expenses, sales costs, and profits for the Part D plans are $180 per enrollee in 2007. The bid information reported by the plans indicates that the average beneficiary will use approximately 35 prescriptions in 2007.

possible explanation for this increase is the possibility that the insurers may have tried to restrain the costs in 2006 to attract market share. The administrative expenses, sales costs, and profits of the Part D insurers were $156 per beneficiary in 2006. They increased by 15% to $180 per beneficiary in 2007.

FIGURE 3: Administrative Costs Charged by Part D Insurers Are Twice as High as the Administrative Costs of Private-Sector PBMs



B. Rebates From Drug Manufacturers

1. Magnitude of Rebates

On average, the Part D insurers negotiated drug manufacturer rebates of $201 per beneficiary in 2007. The cost of the drugs used by the average beneficiary in 2007 is $2,488. The manufacturer rebates negotiated by the insurers will reduce these drug expenses by 8.1%.

The rebate savings vary widely by plan. The plan with the highest rebates reported savings of 12.3%. The plan with the lowest rebates reported savings of less than 4%. Over 14% of the plans reported rebates that reduced drug spending by less than 5%.

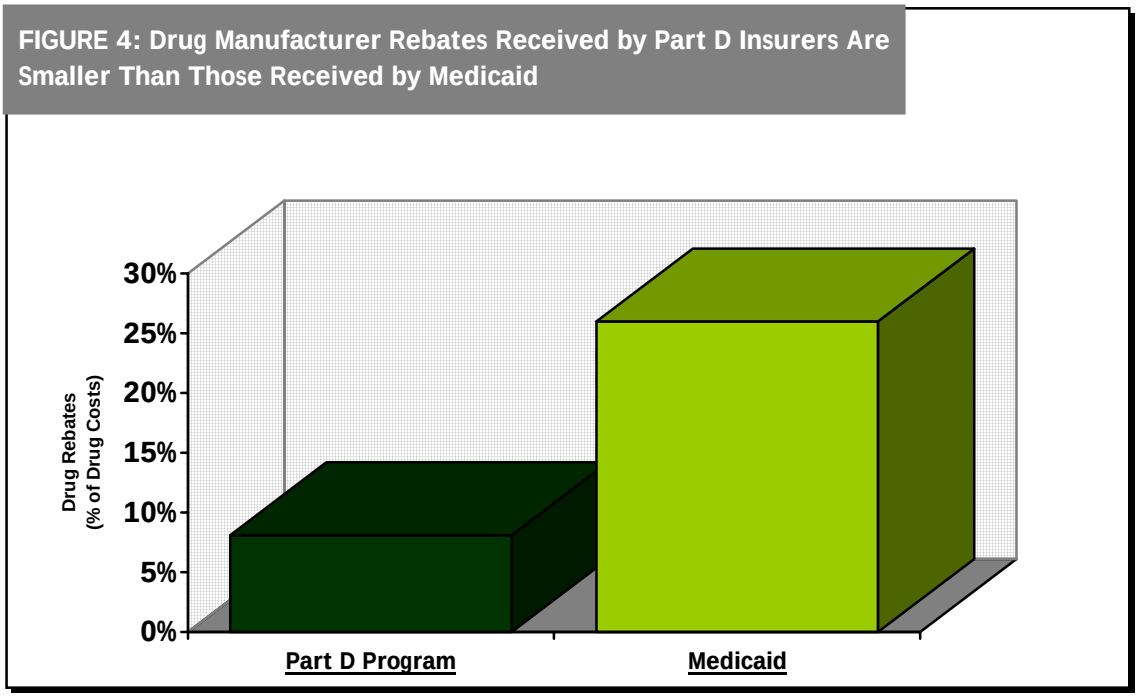
The rebates negotiated by the Part D insurers are much smaller than the rebates received by Medicaid. Manufacturer rebates reduce total Medicaid drug spending by 26%.[26] This is over three times more than the rebates negotiated by the Part D insurers. Figure 4.

[26] Congressional Research Service, *Prescription Drug Coverage Under Medicaid* (2007).

The Part D rebates are also smaller than those achieved by the Pennsylvania PACE, which receives rebates that reduce total drug spending by 22.5%.[27]

Other federal drug programs achieve even larger savings. Public health clinics receive drugs through the Public Health Service "340B" program at discounts of 49% off of the manufacturers' listed Average Wholesale Price.[28] The VA receives average manufacturer list price discounts of 58%.[29] The Department of Defense receives average manufacturer list price discounts of 59%.[30] While these discounts are not directly comparable to the rebates received by the Part D insurers, these other federal programs are obtaining drugs at substantially lower prices than those paid by Medicare Part D.[31]

FIGURE 4: Drug Manufacturer Rebates Received by Part D Insurers Are Smaller Than Those Received by Medicaid



Taxpayers and beneficiaries would realize significant savings if Medicare Part D received the same drug rebates as Medicaid. In the aggregate, the total cost of the drugs used by the 24.1 million Part D beneficiaries will be approximately $60 billion in 2007. Of this amount, approximately $42 billion will be paid for by federal taxpayers and beneficiary

---

[27] Pennsylvania Department of Aging, PACE Assistance Contract for the Elderly 2006 Annual Report (2006).

[28] Congressional Budget Office, Prices for Brand Name Drugs Under Selected Federal Program (June 2005).

[29] Id.

[30] Id.

[31] The 340B, VA, and DOD discounts are not directly comparable to the Part D rebates because they are calculated from different baselines. The 340B, VA, and DOD discounts are calculated as discounts off of the manufacturers' listed Average Wholesale Price. The Part D rebates are reported as a discount off of total drug spending.

premiums, and the remainder will be paid by beneficiaries out-of-pocket.[32] The rebates negotiated by the Part D insurers will reduce this total drug spending by 8.1% or $4.9 billion. If the Part D program obtained rebates as large as those received by Medicaid, drug spending would be reduced by 26% or $15.6 billion, saving taxpayers and beneficiaries an additional $10.7 billion.

In addition to rebates, the Part D insurers occasionally obtain other forms of discounts on prescription drugs from manufacturers. In the aggregate, these other reported discounts are small compared to the manufacturer rebates.[33]

2. Number of Drugs with Rebates

In the aggregate, the Part D insurers report receiving rebates on 637 different drug products. These 637 drugs represent 27% of the over 2,300 drug products used by Medicare Part D beneficiaries.[34] On average, each insurer reports receiving rebates on just 210 different drug products. The number of drugs for which Part D insurers report receiving rebates range from a high of 348 (14% of drugs used by Medicare Part D beneficiaries) to a low of 129 (5% of drugs used by Medicare Part D beneficiaries).

In contrast to the Part D insurers, the Medicaid program obtains a rebate on every drug used by Medicaid beneficiaries. The VA also obtains manufacturer discounts on all drugs used by the program.

In general, the Part D insurers did not obtain rebates for generic drugs. In some cases, the insurers also did not obtain rebates for brand-name drugs.[35] Among the 100 drugs with the highest sales to Medicare beneficiaries, the insurers were unable to obtain rebates on 18 drugs. Fifteen of these drugs were generic drugs; three were brand-name drugs.

3. Drug Manufacturer Windfalls

The inability of the Medicare Part D insurers to obtain significant rebates from the drug manufacturers has resulted in a windfall for the manufacturers, particularly for drugs that are sold to dual-eligible beneficiaries: individuals who qualify for both Medicaid and Medicare.

---

[32] Electronic mail from CMS Actuary to Majority Staff, House Committee on Oversight and Government Reform (Sep. 2007).

[33] For 11 or the 12 Part D insurers, rebates accounted for over 99% of the price concessions obtained from drug manufacturers. One of the smaller of the 12 insurers reported receiving price concessions in the form of discounts rather than rebates. This insurer was excluded from the rebate analysis in this report.

[34] The estimate of the number of drugs used by Part D beneficiaries is a conservative estimate based on data from the Pennsylvania PACE program showing that Pennsylvania seniors participating in Part D used 2,370 different drug products in 2006. Electronic mail from Pennsylvania PACE to Majority Staff, House Committee on Oversight and Government Reform (Aug. 2007).

[35] Electronic mail from Pennsylvania PACE to Majority Staff, House Committee on Oversight and Government Reform (Aug. 2007).

Prior to January 1, 2006, there were 6.2 million Medicare beneficiaries who received their drug coverage through the Medicaid program. Under the Medicaid program, drug manufacturers paid average rebates of 26% on the drugs used by these beneficiaries. After January 1, 2006, these dual-eligible beneficiaries were switched to the Medicare Part D coverage. Average rebates under the Part D program are only 8.1%, resulting in substantial extra revenue for the drug manufacturers. Drug manufacturers have acknowledged some of these windfalls. In its 2006 quarterly financial reports, the drug manufacturer Pfizer reported that the shift of dual-eligible beneficiaries to the Medicare Part D program had resulted in a $300 million windfall.[36]

The dual-eligible beneficiaries will use an estimated $15.4 billion worth of drugs in 2007.[37] Under Medicaid, drug manufacturers would pay $4.0 billion in rebates for drug expenditures of $15.4 billion. Under Medicare Part D, the manufacturers will pay only $1.2 billion in rebates. The difference in the size of the rebate payments — $2.8 billion — represents a significant increase in drug manufacturer profits.

4. CMS Errors

During the preparation of this report, the Committee staff discovered errors made by CMS actuaries in calculating the extent of drug manufacturer rebates. The 2007 report of the Medicare Trustees states that the Part D insurers negotiated rebates that reduced total drug spending by 4.6%.[38] The correct figure is 8.1%. After consultation with the Committee staff, CMS actuaries confirmed that they had made a calculation error of approximately $2.1 billion. This mistake resulted from certain insurers leaving rebate fields blank in bid documents, despite the fact that they were in fact obtaining rebates, and CMS failing to correct for these omissions.

C. Drug Rebates in Coverage Gaps

The Medicare Modernization Act provides that the Part D insurers "shall provide" beneficiaries in coverage gaps with "access to negotiated prices," including "all discounts, direct or indirect subsidies, rebates, other price concessions, or direct or indirect remunerations."[39] When CMS issued regulations implementing the new law, the

---

[36] Pfizer, Inc., *2006 Quarterly Reports* (2006)

[37] This estimate assumes conservatively that the average drug utilization for dual-eligible beneficiaries is the same as the average drug utilization for Medicare Part D beneficiaries. According to some estimates, utilization is likely to be higher for these dual-eligible beneficiaries than for other beneficiaries, their aggregate drug use is also likely to be higher. See, e.g., CBO, *A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit* (July 2004).

[38] Centers for Medicare and Medicaid Services, Medicare Advantage, Cost, PACE Demo, and Prescription Drug Plan Contract Report – Monthly Summary Report (July 2007).

[39] Public Law 108-173, § 1860D-2(d)(l). The law provides:

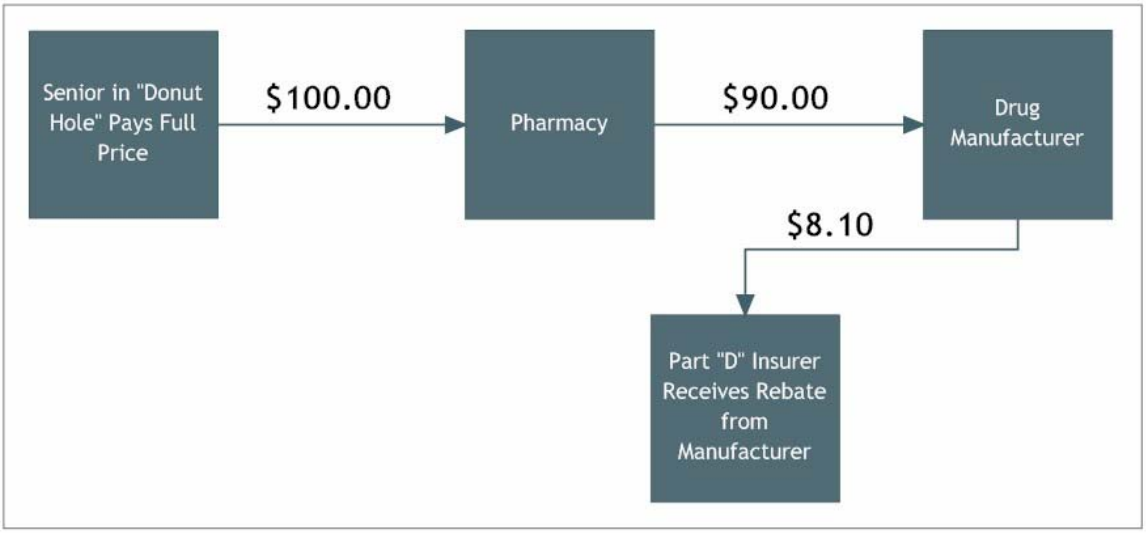
> Under qualified prescription drug coverage offered by a PDP sponsor offering a prescription drug plan or an MA organization offering an MA-PD plan, the sponsor or organization shall provide beneficiaries with access to negotiated prices used for payment for covered part D drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of a

agency assumed market forces could be relied upon to ensure that these price concessions would be passed on to consumers.[40]

Despite the requirements of the law, 11 of the 12 Part D insurers will not pass the drug rebates they receive in 2007 through to beneficiaries in the form of lower prices at the pharmacy counter. Two of the 12 insurers indicated that they did pass through some or all of the rebates to beneficiaries in 2006. According to one of these insurers, however, this practice was discontinued in 2007.

The failure to use rebates to reduce drug prices at the pharmacy has its greatest impact on beneficiaries in coverage gaps, such as the donut hole. These beneficiaries pay the full costs of the drugs out-of-pocket. A portion of this purchase price — 8.1% on average — then flows back to the insurer in the form of a rebate. In effect, beneficiaries in coverage gaps pay inflated drug prices to fund rebates paid to the Part D insurers. Figure 7 illustrates how this flow of funds works for Part D insurers, pharmaceutical manufacturers, and plan beneficiaries.

Figure 7: Flow of Payments for a Typical Brand Name Drug Under Medicare Part D



The bid information reported by the plans indicates that in 2007, Part D beneficiaries in coverage gaps will pay $12.7 billion in out-of-pocket drug costs. Although these costs will be paid by the beneficiaries, the Part D insurers will receive significant rebates from the drug manufacturers. Assuming an average rebate of 8.1%, the total rebates received by the Part D insurers on these out-of-pocket purchases by beneficiaries will be $1.0 billion.

> deductible or other cost-sharing or an initial coverage limit (described in subsection (b)(3)). … For purposes of this part, negotiated prices shall take into account negotiated price concessions, such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations, for covered part D drugs, and include any dispensing fees for such drugs.

[40] Department of Health and Human Services, *Medicare Program: Medicare Prescription Drug Benefit*, 70 Fed. Reg. 4194 (Jan. 28, 2005).

The Part D insurers claim that they use these rebates to reduce drug plan premiums, providing an actuarially equivalent benefit to beneficiaries. However, this does not appear to be accurate. On average, 75% of the costs of plan premiums are paid by the federal government, not the beneficiary. This means that beneficiaries would at most realize only a 25 cent reduction in premiums for each dollar of rebates retained by the insurers. Moreover, several of the Part D insurers informed the Committee staff that they do not use all of the rebates they receive from manufacturers to reduce premiums. They conceded that they retain a portion of these payments as profits.

There are also distributional impacts from the insurers' practice of retaining the rebates. Even if the full amount of the rebates were passed through to beneficiaries in the form of lower premiums, this practice would result in an indirect subsidy from beneficiaries with high out-of-pocket drug costs to beneficiaries with low out-of-pocket costs.

D. Increases in Drug Manufacturer List Prices

The Part D insurers generally set prices for brand-name drugs at the pharmacy using a formula that relies upon a fixed discount off of the published "Average Wholesale Price" (AWP), plus a small fee for each prescription filled by the pharmacy. Because AWP is a list price set by the manufacturer, these pricing formulas leave both beneficiaries and taxpayers vulnerable to manufacturer price increases. According to the Congressional Budget Office, AWP functions like a vehicle "sticker price" and typically exceeds actual wholesale costs by over 25%.[41]

Most of the Part D insurers who provided information on their pricing formulas use similar formulas. For the plans offered by these insurers, the discount off of the AWP for brand-name drugs ranged from 13.5% to 16.5%, and pharmacy filling fees ranged from $1.75 to $4.00 per prescription. The average brand-name drug price formula for the Part D insurers was AWP minus 15%, plus $2.10.[42] For a typical brand-name drug with a listed AWP of $100, the formula of AWP minus 15% plus $2.10 would result in a final cost to the Medicare Part D beneficiary of $87.10. Pharmacies that participate in a Medicare drug plan must agree to charge the formula-based price for each drug.

In practice, these AWP-based pharmacy prices do not represent significant savings off of prices available to individuals who do not have prescription drug coverage. A number of studies have compared the insurers' pharmacy prices to prices available from other discount providers, such as Costco, Drugstore.com, or Wal-mart. They have found that the Part D pharmacy prices are no lower than prices typically available at low-cost pharmacy retailers or mail-order services.[43] The AWP-based prices set by the Part D

---

[41] Congressional Budget Office, *Prices for Brand Name Drugs Under Selected Federal Program* (June 2005).

[42] Pharmacy prices for generic drugs are established in a similar formula, either through a formula based on AWP or a Maximum Acquisition Cost (MAC) established by the insurers.

[43] House Committee on Government Reform, Minority Staff, *New Medicare Drug Plans Fail to Provide Significant Price Discounts* (Nov. 22, 2005).

insurers are also similar, and in some cases higher, than the pre-rebate prices Medicaid pays for drugs at the pharmacy.[44]

One consequence of these pricing formulas is that increases in manufacturer list prices are passed through to beneficiaries. Since the Part D program went into effect in January 2006, the average list price for the 25 most popular brand-name drugs used by Part D beneficiaries has increased by 8.9%.[45] This is almost twice as fast as the overall inflation rate.[46] The list prices for 13 of the top 25 drugs increased by 10% or more, with the list prices of one of the drugs increasing by 25%.[47] These price increases result in higher out-of-pocket costs for beneficiaries in coverage gaps. They also result in higher copays for beneficiaries in plans that establish copays as a percentage of the pharmacy drug price.

For taxpayers, these increases in AWP raise the cost of covering low-income beneficiaries, whose coverage is subsidized by federal taxpayers. The price increases also mean higher costs for coverage in the catastrophic portion of the benefit, where the costs are also heavily subsidized by taxpayers.

E. Use of Generic Drugs

The private Part D insurers have a mixed record in promoting the use of generic drugs. In 2007, 59% of all Part D prescriptions will be filled with generic drugs. This level of generic drug use is higher than the level achieved by Medicaid, which fills 54% of its prescriptions with generic drugs.[48]

Other government programs, however, are better at increasing generic drug use than Medicare Part D. For example, the VA fills 68% of its prescriptions with generic drugs.[49]

CONCLUSION

An analysis of proprietary cost and pricing data from Medicare Part D insurers reveals that the use of the private insurers to deliver the Medicare drug benefit results in significant administrative expenses and has produced only limited savings on drug prices. If the Medicare Part D program reduced administrative expenses to the level achieved by

---

[44] Congressional Research Service, *Prescription Drug Coverage Under Medicaid* (2007).

[45] Medi-Span, Price Alert: The Official Guide to AWP Pricing (Jan. 2006): Medi-Span, Price Alert: The Official Guide to AWP Pricing (Aug. 2007).

[46] The overall inflation rate has increased by 4.8% since January 2006. Bureau of Labor Statistics, *Consumer Price Index – All Urban Consumers* (2007).

[47] Medi-Span, *Price Alert: The Official Guide to AWP Pricing* (Jan. 2006): Medi-Span, *Price Alert: The Official Guide to AWP Pricing* (Aug. 2007).

[48] Department of Health and Human Services, Office of Inspector General, *Generic Drug Utilization in State Medicaid Programs* (OEI-05-05-00360) (July 2006).

[49] CRS, Pharmaceutical Costs: A Comparison of Department of Veterans Affairs, Medicaid, and Medicare Policies (Jan. 19, 2007).

traditional Medicare and negotiated drug rebates equivalent to those obtained by Medicaid, taxpayers and beneficiaries would save almost $15 billion in 2007.

The data also reveal that the Medicare Part D insurers are not passing drug rebates through to beneficiaries in coverage gaps and have established pricing formulas that leave beneficiaries and taxpayers vulnerable to increases in manufacturer list prices. One positive result achieved by the Part D insurers is a higher rate of utilization of generic drugs than achieved by Medicaid.