



STATEMENT FOR THE RECORD
SUBMITTED TO THE
Energy and Commerce Health Subcommittee
on
Prescription Drug Price Inflation:
Are Prices Rising Too Fast?

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Mr. Chairman and Members of the Health Subcommittee, my name is Bonnie Cramer. I am Chair of the Board of Directors of AARP. On behalf of our nearly 40 million members, I want to thank you for holding this timely hearing and including AARP in this discussion about brand-name prescription drug prices.

AARP is committed to improving the lives of our members and all older Americans. And, whether we're ready to admit it or not, the United States is aging at an unprecedented rate. Between 2010 and 2050, the population age 65 and older is expected to more than double, rising from 40 million to 87 million, and the 85+ population is expected to more than triple, growing from 6 million to 21 million.¹ Perhaps a more understandable way of explaining this is that, starting on January 1, 2011, 10,000 people will turn 65 every day—and that this will continue for the next 20 years.²

When combined with rapidly escalating brand-name prescription drug prices and the fact that older Americans use prescription drugs more than any other segment of the U.S. population, it seems evident that many Americans will soon find themselves unable to access the drugs they need at a price they can afford. And that, we believe, is not acceptable.

AARP Watchdog Monitors Prescription Drug Price Increases

AARP is deeply committed to making prescription drugs affordable for our members – and all Americans. As part of these efforts, AARP's Public Policy Institute has been reporting on manufacturer price changes for prescription drug products since 2004. To help address concerns about the impact that rising drug prices have on all Americans, AARP has been monitoring prices for specific drugs at regular intervals and reporting our findings—both favorable and unfavorable—to its members and to the public.

¹ AARP Public Policy Institute analysis of U.S. Census Bureau, Population Projections, U.S. Interim Projections by Age, Sex, Race, and Hispanic Origin: 2000-2050.

² Alliance for Aging Research, *The Silver Book*, 2009.

AARP has released multiple reports on a quarterly and annual basis, and has consistently found that manufacturer price increases for brand-name drug products widely used by older Americans have far outstripped the price increases for other consumer goods and services. The results of these reports have been widely reported in the press and have also been cited in numerous publications. These reports, combined with our advocacy and education efforts, reflect our deep commitment to making prescription drug prices affordable for all Americans.

Our latest report found that average manufacturer prices for widely used brand-name and specialty prescription drugs continued to increase substantially between October 2008 and September 2009, rising by 9.3 percent and 10.3 percent, respectively. In contrast, prices for common generic drugs declined by 8.7 percent over the same time period. These trends resulted in an overall average annual rate of increase of 5.4 percent, a sharp contrast to the negative rate of general inflation for all consumer goods and services.³

Price Increases Impact Medicare Beneficiaries

Approximately 20 million of AARP's members are over the age of 65 and enrolled in the Medicare Part D prescription drug benefit, which provides much-needed prescription drug coverage for Medicare beneficiaries. Studies continue to demonstrate that individuals who have affordable access to prescription drugs are more likely to adhere to their prescription drug treatment regimens.⁴ This not only leads to better health outcomes, but also helps patients avoid unnecessary health care utilization.

³ S. Schondelmeyer, L. Purvis, and D. Gross, "Rx Watchdog Report: Drug Prices Continue to Climb Despite Lack of Growth in General Inflation Rate," AARP Public Policy Institute, November 2009.

⁴ J. M. Madden et al., "Cost-Related Medication Nonadherence and Spending on Basic Needs Following Implementation of Medicare Part D," *Journal of the American Medical Association* 299, no. 26: 1922–1928; B.A. Briesacher, J.H. Gurwitz, and S.B Soumerai, "Patients At-Risk for Cost-Related Medication Nonadherence: A Review of the Literature," *Journal of General Internal Medicine* 22, no 6: 864–87.

We are pleased to see that the majority of Medicare beneficiaries enrolled in the Part D benefit are satisfied with the program.⁵ The standard Part D benefit has an annual deductible (\$295 in 2009) and initial coverage period where beneficiaries pay for 25 percent of their drug costs and their plan pays for 75 percent of the drug costs until total drug costs reach the initial coverage limit (\$2,700 in 2009). After this point, beneficiaries fall into the dreaded Part D “doughnut hole”, where the beneficiary must shoulder the entire cost of their drugs (as well as their premiums) until they reach catastrophic coverage (\$6,154 in total drug costs). After this point, the beneficiary pays 5 percent of the cost of their drugs, their prescription drug plan pays 15 percent, and Medicare pays the remaining 80 percent.

More than 3 million Americans are at risk of falling into the Medicare Part D doughnut hole this year and feeling first hand the impact of rising prescription drug prices.⁶ Countless AARP members tell us of their experiences getting caught in the doughnut hole trap. That is why we have made closing the doughnut hole one of our top priorities this year as part of the health care reform effort.

For example, we heard from Joyce in Illinois who enrolled in Medicare Part D and has fallen in the doughnut hole. She tells us that when she falls into the doughnut hole, she can no longer afford her medications (even with cutting back other basic living expenses like groceries). Instead of taking her insulin five times a day as prescribed, she takes only one or two shots every few days, even though she knows that such behavior will only worsen the complications of her diabetes. Another AARP member, Martha from Ohio, describes the doughnut hole as “a nightmare”. When she enters the doughnut hole, she takes her

⁵ P. Neuman and J. Cubanski, “Medicare Part D Update — Lessons Learned and Unfinished Business,” *New England Journal of Medicine* 361, no. 4: 406-414.

⁶ J. Hoadley et al., “The Medicare Part D Coverage Gap: Costs and Consequences in 2007,” Kaiser Family Foundation, August 2008.

medication every other day (rather than the daily recommended dose) or tries to cut her medications in half. She has also resorted to paying for her medications using her credit cards, but is rapidly reaching her credit limit. Finally, Shari in Virginia tells us that she and her husband have had to move in with their youngest son. She has fallen into the doughnut hole and now has to rely on her children to help pay for her prescription drug costs. Her children are raising their own children, and while they are able to provide some assistance, she recognizes that this help has its limit as their expenses are skyrocketing just like everyone else's.

These are just a few of the stories we hear from our members. Unfortunately, more and more people will be feeling the effects of the doughnut hole in the future. The structure of the Medicare Part D benefit is tied to prescription drug spending – not the Consumer Price Index (inflation) or a more realistic index as AARP has advocated – which is directly linked to prescription drug prices. As a result, the benefit's threshold amounts are growing each year. For example, under current law, the doughnut hole is projected to almost double by 2016, to more than \$6,000. Thus, Part D enrollees could, upon entering the coverage gap, face the prospect of remaining in the gap while paying the full cost of their prescriptions far longer in the future. In combination with higher prescription drug prices, this will undoubtedly lead even more Medicare beneficiaries who reach the coverage gap to forgo needed brand-name medications, a phenomenon that is already being documented.⁷

Price increases also impact Medicare Part D enrollees' cost-sharing for their brand-name prescription drugs. Part D plans use tiers that group drugs by similar cost-sharing requirements. For example, Tier 1 drugs, usually generics, have the lowest copayments. Tier 2 drugs, "preferred" brands, have a higher copayment. Tier 3 drugs are "nonpreferred" brand-name drugs that are usually more expensive and/or have more safety concerns than "preferred" drugs.

⁷ Id.

An AARP Public Policy Institute analysis of most national Part D plans shows that, in 2010, more plans will require copayments close to \$100 for Tier 3 drugs, which are usually “nonpreferred” brand-name drugs.⁸ Other plans will use coinsurance for all brand-name medicines (across tiers), which can reach as high as 65 percent. In contrast, cost-sharing for generic prescription drugs, with manufacturer prices that have actually dropped over the past few years, has remained at \$7 or less.

In addition, since Part D plans began in 2006, many have incorporated a fourth tier as well, often known as a “specialty” tier. This includes many biologics and injectable drugs; coinsurance is the usual form of cost-sharing. Coinsurance represents a percentage of the drug’s price, rather than a copayment that is a fixed amount regardless of the drug’s price. In 2009, more than half of all Part D enrollees in plans with a specialty tier were subject to 33 percent coinsurance for specialty tier drugs. Since 2006, the number of national PDPs charging 33 percent coinsurance for specialty tier drugs has increased considerably, when only four of the 35 national or near-national PDPs charged this rate.⁹ To put this in perspective, rheumatoid arthritis medicines such as Enbrel and Humira averaged \$1,633 per prescription in 2008. The average cost of a multiple sclerosis drug was \$2,006.¹⁰ At 33 percent coinsurance, enrollees’ cost would exceed \$500 per prescription. Most patients with either of these conditions filled at least eight such prescriptions in 2008.¹¹

⁸ N.L. Rucker and L. Purvis, “Medicare Beneficiary Costs Set to Rise For Part D Drug Benefit in 2010,” AARP Public Policy Institute, November 2009.

⁹ J. Hoadley et al., “Medicare Part D 2009 Data Spotlight: Specialty Tiers,” Kaiser Family Foundation, June 2009.

¹⁰ Express Scripts, *2008 Drug Trend Report*, April 2009, available at <http://www.expressscripts.com/industryresearch/industryreports/drugtrendreport/2008/>.

¹¹ Id.

Given that specialty drugs are currently among the most expensive on the market, with prices that can range from \$5,000 to \$300,000 per year,¹² it is inevitable that many individuals who use specialty drugs will fall into the doughnut hole. Further, prices for these prescription drugs – many of which are biologic drugs – continue to rise at an alarming rate. In fact, AARP has found that the manufacturer prices for specialty prescription drugs widely used by older Americans rose by 10.3 percent in the last year. This is particularly striking given that most biologic drugs studied currently do not face generic competition.

Price Increases Impact Medicare

AARP is cognizant that prescription drug price increases not only impact individual spending, but also the costs borne by the Medicare program (and, by extension, taxpayers). As previously mentioned, the Medicare program pays for 80 percent of Part D enrollees' prescription drug costs after they reach the catastrophic cap. In addition, the Medicare program offers substantial financial assistance to low-income Medicare beneficiaries who qualify for the Low-Income Subsidy (LIS). These individuals receive additional help with their Part D premiums and copayments; also, upon entering the doughnut hole, they do not experience the shock of full-cost prescriptions: their subsidized cost-sharing of only a few dollars per prescription continues unchanged. While we obviously applaud this much needed assistance to lower-income beneficiaries, the fact remains that the Medicare program is responsible for paying for the vast majority of the prescription drug costs for these individuals. Last month, the Medicare Payment Advisory Commission (MedPAC) estimated that LIS enrollees accounted for over 50 percent of all Part D spending in 2007, although these enrollees only made up 38 percent of total enrollment.¹³

¹² B. Walsh, "The Tier 4 Phenomenon: Shifting the High Cost of Drugs to Consumers," AARP Strategic Analysis & Intelligence, March 2009.

¹³ S. Suzuki and J. Sokolovsky, "Comparing LIS and Non-LIS Beneficiary Experience With Part D," MedPAC, September 17, 2009, available at <http://www.medpac.gov/transcripts/LIS%20and%20non-LIS%20beneficiary%20experience%20w%20Part%20D%20public.pdf>.

It should also be noted that Medicare Part D is not the only source of prescription drug coverage for Medicare beneficiaries. Medicare Part B covers prescription drugs that are administered in an outpatient setting, and beneficiaries are responsible for 20 percent of their costs. Thus, unless beneficiaries have some source of supplemental coverage, prescription drug price increases impact them directly. Further, unlike Medicare Part D, Medicare Part B does not have catastrophic coverage, so beneficiaries are responsible for their share of prescription drug costs indefinitely.

In 2007, the Medicare Part B program spent \$17 billion on prescription drugs – most of which are biologic drugs.¹⁴ The top six biologics represented \$7 billion of the total, or 43 percent of all Part B drug spending.¹⁵ To put this in context, Medicare Part B spending for one biologic drug—Epoetin alfa—in 2007 (\$2.6 billion) was greater than the FDA’s, with over 10,000 employees, entire FY2008 budget (\$2.3 billion).¹⁶

Medicare Parts D and B are financed through the Supplementary Medical Insurance Trust Fund, which is financed through premiums and general revenues. Thus, as prescription drug prices continue to increase, spending will grow correspondingly, which means all Medicare beneficiaries – as well as all taxpayers – will be required to pay more in order to keep the programs solvent.

AARP is very concerned about the millions of Americans with Medicare Part D prescription drug coverage that fall into the doughnut hole each year. To help Medicare beneficiaries and their caregivers, AARP has created the Doughnut Hole Calculator – available at <http://doughnuthole.aarp.org/> – an online tool that

¹⁴ MedPAC, *Report to the Congress: Improving Incentives in the Medicare Program, Chapter 5: Medicare Payment Systems and Follow-on Biologics*, June 2009.

¹⁵ *Id.*

¹⁶ U.S. Department of Health and Human Services, “HHS: What We Do,” available at <http://www.hhs.gov/about/whatwedo.html>; and MedPAC, *Report to the Congress: Improving Incentives in the Medicare Program, Chapter 5: Medicare Payment Systems and Follow-on Biologics*, June 2009.

helps individuals find lower-cost, effective drugs that might help them avoid the coverage gap. The calculator is an easy way for people to view a graph of their out-of-pocket spending by month, look up lower cost drugs for their conditions, create a Personal Medication Record and print out personalized letters to their doctors to help start a conversation about safely switching prescriptions. Since it was launched in July of 2009, over 180,000 individuals have used the calculator.

Price Increases Also Impact the Under-65 Population

Of course, AARP is fully aware that Medicare beneficiaries are not the only ones suffering the effects of rising prescription drug costs. For example, a large majority of covered workers have some sort of tiered cost-sharing formula for prescription drugs. For covered workers in plans with four cost-sharing tiers, 41 percent face a copayment for fourth-tier drugs and 29 percent face coinsurance.¹⁷ The average copayment for drugs on this tier is \$85 and the average coinsurance is 31 percent.¹⁸

These plans also do not have safety nets such as stop-loss or catastrophic coverage, so beneficiaries are responsible for an unlimited share of drug costs. Also, unlike Medicare, there are no special subsidies for low-income consumers in the commercial marketplace. And of course, this does not include the millions of those without health insurance, including over 7 million adults age 50 to 64 who are uninsured.¹⁹ Non-disabled older adults generally do not have access to coverage through a public program, even if they have no access to private insurance and limited income.²⁰ Therefore, unless they somehow gain access to private insurance, the uninsured population age 50 to 64 faces the very real

¹⁷ Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits: 2009 Annual Survey*, September 2009.

¹⁸ *Id.*

¹⁹ G. Smolka, L. Purvis, and C. Figueiredo, "Health Care Reform: What's at Stake for 50- to 64-Year Olds?" AARP Public Policy Institute, March 2009.

²⁰ *Id.*

possibility of being completely exposed to prescription drug price increases until they become eligible for Medicare at age 65.

Unfortunately, the inability to afford needed prescription drugs has been shown to negatively impact patient adherence. Many consumers report that they have not filled prescriptions, skipped doses, or cut pills in half as a result of high prescription drug prices.²¹ Problems paying for prescription drugs are even more common among those who take larger numbers of medications (i.e., older adults).

In fact, several large surveys have shown that older adults, who are disproportionately affected by chronic disease²² and more likely to need a chronic medication,²³ resort to skipping doses, reducing doses, and letting prescriptions go unfilled when faced with increased medication costs.²⁴ Research has also found that high cost sharing delays the initiation of drug therapy for patients newly diagnosed with chronic disease.²⁵ These behaviors, in turn, can lead to expensive hospitalizations and adverse health outcomes²⁶ that must then be paid for by patients and taxpayers.

²¹ USA Today/Kaiser Family Foundation/Harvard School of Public Health, *The Public on Prescription Drugs and Pharmaceutical Companies*, March 2008.

²² U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Healthy Aging: Preserving Function and Improving Quality of Life Among Older Americans*, 2008, January 2008.

²³ C. M. Roe, A. M. McNamara, and B. R. Motheral, "Use of Chronic Medications among a Large, Commercially-Insured U.S. Population," *Pharmacoepidemiology and Drug Safety* 11, no. 4: 301–309.

²⁴ J. M. Madden et al., "Cost-Related Medication Nonadherence and Spending on Basic Needs Following Implementation of Medicare Part D," *Journal of the American Medical Association* 299, no. 26: 1922–1928.

²⁵ M.D. Solomon et al., "Cost Sharing and the Initiation of Drug Therapy for the Chronically Ill," *Archives of Internal Medicine* 169, no. 8: 740–748.

²⁶ H. Kohl and W. H. Shrank, "Increasing Generic Usage in Medicare Part D: The Role of Government," *Journal of the American Geriatric Society* 55: 1106–1109.

Health Care Reform Moving Forward

AARP was pleased to endorse the Affordable Health Care for America Act (H.R. 3962) and Medicare Physician Payment Reform Act of 2009 (H.R. 3961) that recently passed in the U.S. House of Representatives. For years AARP has been fighting to make sure that our members – and all Americans – have access to affordable health care coverage. The Affordable Health Care for America Act will protect and strengthen Medicare for current and future Medicare beneficiaries; require new, no-cost Medicare coverage of important preventive services like screenings for cancer, diabetes, and osteoporosis; and take steps to prevent waste, fraud, and abuse and inefficiency in the Medicare program. H.R. 3961 would permanently fix the flawed Medicare physician payment formula to help to ensure that physicians will continue to treat Medicare patients. For individuals who are under 65, the legislation will provide for a 2 to 1 age rating, meaning that insurance companies would be limited in how much they can charge an individual based solely on age. The legislation will also provide for affordable health insurance options for people who currently lack access to or cannot afford to purchase health insurance.

Key to our endorsement was a measure that would prevent millions of seniors from having to pay thousands of dollars in out of pocket costs for their prescriptions. Starting next year, the House health care reform bill would reduce the size of the Medicare Part D coverage gap or “doughnut hole” by \$500. The bill would completely eliminate the gap in coverage in 10 years. In addition, the legislation would provide for a 50 percent discount on brand name drugs in the coverage gap. Closing the doughnut hole will help Medicare beneficiaries obtain affordable access to the prescription drugs that they need, which will not only improve their quality of life, but will help to reduce unnecessary, costlier treatments associated with medication non-compliance.

In addition, we support the House health care bill's provisions that would grant the Secretary of Health and Human Services the authority to negotiate on behalf of Medicare beneficiaries. It's a common sense approach to strengthening Medicare's ability to provide lower cost prescription drugs. The private sector already uses its bargaining clout to negotiate better prices for prescription drugs. It is time to also permit the Secretary to use the bargaining power of millions of Medicare members to get the best price possible. Medicare has an obligation to all Americans to be a prudent purchaser of health care services. The Secretary will determine how to use negotiating authority to achieve that end.

Currently, medication therapy management (MTM) services must be offered by Medicare Part D plans to enrollees (at no additional charge) who incur total Part D prescription drugs costs of at least \$4,000 in 2009 (this threshold drops to \$3,000 in 2010, per CMS guidance). Enrollees deemed eligible for MTM services must also meet plan-determined criteria related to the total number of different covered drugs, and the types of chronic diseases enrollees must have. Unfortunately, only a tiny proportion of MTM-eligible Part D enrollees have actually received MTM services, and even fewer have received in-person medication reviews from pharmacists or other health care professionals.²⁷ We were pleased to see that the House health care reform bill included provisions that would provide federal grants to promote medication therapy management (MTM) services. These grants would be given to establish community-based, multidisciplinary teams to support primary care practices that include pharmacist-delivered MTM services. Such grants would also be used to implement these services for treatment of chronic diseases. Further, performance bonuses would be provided to Part D plans that went above and beyond what is currently required under Medicare. Through these grants, pharmacists could not only review more patients' treatment regimens for lower-cost options, but more importantly could work with enrollees to ensure appropriate use of prescribed

²⁷ However, starting in January 2010, new CMS guidance governing MTM services will require plans to communicate with both enrollees and their prescribers, to provide an annual comprehensive medication review, and to provide quarterly targeted reviews.

medications, help manage drug-related risks, and minimize preventable drug-related medical visits and hospitalizations. Expansion of such services could promote the full value of drug therapy, while helping to keep overall program costs in check.

Finally, H.R. 3962 would provide individuals who are currently uninsured with access to health insurance coverage. Providing such coverage will help these individuals gain more affordable access to prescription drugs. Thus, they are more likely to adhere to their prescription drug treatment regimens, which will lead to better health outcomes and help to avoid unnecessary, costlier medical interventions.

As Congress continues to move forward in enacting health care reform, we appreciate provisions in the Senate health care reform proposal that would help to address rising prescription drug costs. We support provisions in the Senate bill that would reduce brand-name prescription drug costs by 50 percent for individuals while they are in the doughnut hole. However, we have strongly urged the Senate to go further and fully close the doughnut hole as President Obama has promised.

AARP supports prescription drug importation legislation and has endorsed the bipartisan legislation sponsored by Representatives Berry and Emerson (H.R. 1298). In the quest for lower-priced prescription drugs, many Americans resort to importing prescription drugs from abroad. This legislation would create a framework for the safe, legal importation of prescription drugs that will better protect the health and pocketbooks of those desperate for lower priced prescription drugs. We are also very pleased to see that the legislation includes a number of safety requirements including inspections and measures to prevent the counterfeiting of imported drugs. AARP is supporting the bipartisan amendment sponsored by Senators Dorgan, Snowe, McCain, Grassley and Stabenow that would attach this legislation to the comprehensive health care

reform package being considered in the Senate. We urge Congress to enact this legislation this year.

AARP strongly supports the Promoting Innovation and Access to Life-Saving Medicine Act (H.R. 1472). We applaud Chairmen Waxman and Pallone and Congressman Deal and Congresswoman Emerson for putting this critical legislation forward on behalf of America's consumers. This legislation would provide a workable pathway for the FDA-approval of safe, effective, generic forms of biologic drugs and would provide for a balanced period of exclusivity. This bill is based on the successful framework of the Hatch-Waxman law passed decades ago and has proven to save consumers and the federal government billions of dollars.

Unfortunately, both the House-passed health care reform legislation and the bill currently being debated on the Senate floor include biologic provisions that would provide for an imbalanced 12 year period of exclusivity for the branded product. According to the Federal Trade Commission (FTC), brand name manufacturers do not need special incentives to support continued innovation, and the unreasonable twelve to fourteen years of market exclusivity supported by the drug industry actually negatively impacts innovation.²⁸ As noted by the Medicare Payment Advisory Commission (MedPAC), brand name companies have little incentive to improve their products without the threat of imminent competition.²⁹ We urge Congress to change this unreasonable exclusivity period and make these generic biologic drugs available as soon as possible. Many of our members have told us the costs of these are simply unaffordable. Biologic drugs cannot save anyone's lives if people cannot afford them.

²⁸ Federal Trade Commission Report, *Emerging Health Care Issues: Follow-on Biologic Drug Competition*, June 2009.

²⁹ MedPAC, *Report to the Congress: Improving Incentives in the Medicare Program, Chapter 5: Medicare Payment Systems and Follow-on Biologics*, June 2009.

Conclusion

Thank you again for your continuing efforts to improve our nation's health care system. We look forward to working with you to ensure that prescription drugs remain affordable for our members, all Americans, and all health care payers. I appreciate the opportunity to be with you today and I look forward to answering any questions you may have.