

**The Center for Hospital  
Finance and Management**

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Dear Congressman Waxman

I have reviewed the Medicare Savings Act of 2011 and I concur with the Congressional Budget Office that it will generate significant savings to the federal government. I do not see any evidence that it will lead to cost shifting to the Medicare beneficiary.

First, it is important to note that the prices that US pays for brand name drugs are approximately twice as high as other industrialized countries. There is no economic reason why the US should be paying so much higher prices for brand name drugs.

Second, it is important to note that among the government programs, Part D plans pay the highest rates for drugs. The VA, Department of Defense and other federal government programs pay significantly lower prices.

Third, it is important to note that the prices for drugs increased when the responsibility for the dual eligibles and low income individuals was transferred from the Medicaid to the Medicare program. The difference is approximately \$10 billion per year.

I have been working with the states on the design of their Medicaid programs and I do not see any evidence that the drug rebate program operated by the Medicaid program since 1990 has had any adverse impact on the prices paid by other payors. There was one study that showed that the best price provisions could have a small impact on other payors, but the empirical result was statistically insignificant. The bottom line is that the Medicaid program has been operating a drug rebate program for years without any adverse impact on the Medicare or on the private sector. In the past the drug rebate program included the dual eligibles. All this legislation would do is to return the rebates to the pre Medicare Modernization Act period.

I have also examined if the size of the Medicaid rebate affects the formula that the state Medicaid program uses for reimbursing drugs. There is no connection between the size of the rebate and the formula that the state uses to pay for drugs. It is likely therefore that the formula that the Part D plans use to determine their payment rate will be unaffected by the size of the rebate. Part D plans will negotiate the best price that they can and then the rebate will be applied.

My expectation based on my analysis of the Medicaid rebate program is that expanding the rebate to include dual eligibles and low income individuals will lower the out of pocket costs and premiums for all

Medicare enrollees. This is because the prices paid to the drug companies will be lower. These lower costs will be passed on to the Medicare beneficiaries.

This legislation will allow the federal government to get the same rebate as the Medicaid program used to receive for dual eligibles. There is no reason why the Medicaid recipient who becomes eligible for Medicare should automatically receive a lower rebate than someone that is not Medicare eligible. The cost of filling the prescription is the same and the cost of dispensing the prescription is the same.

The main problem that this legislation is trying to resolve is that the Part D plans have been unable to obtain as low a price as the Medicaid program. This will bring the prices more in line across the federal programs and reduce the variation that the federal government pays for drugs. The way the provision is structured if the Part D plans are able to get comparable prices to the Medicaid program, then the Part D plans would not have to pay a rebate. It is only because the Part D plans pay higher prices than Medicaid that a rebate is needed.

The assumption that drug companies can cost shift to Part D plans assumes that the Part D plans are not price sensitive and unable to negotiate effectively with the drug companies. The Part D plans negotiations are based on the price the part D plan can negotiate with the drug company. The negotiation is not affected by what Medicaid is paying. It is not affected if the rebate is paid for dual eligibles or not.

Drug companies spend only 14 percent of their budget on research and development. Increasing the rebate to dual eligibles will not have an impact of the research and development of drug companies. It is more likely to affect their marketing which typically represents over 30 percent of their spending.

Sincerely,

A handwritten signature in black ink, appearing to read "Gerard A.", with a long horizontal stroke extending to the right.

Gerard Anderson, PhD

Professor, Johns Hopkins University

Director Johns Hopkins Center for Hospital Finance and Management