

BUILDING ON WHAT WORKS: RESTORING MEDICARE DRUG REBATES**Background:**

Upon passage of the Medicare Modernization Act (MMA), millions of older adults and people with disabilities gained access to prescription drug coverage through private plans approved by the federal government, known as Medicare Part D. As of September 2015, more than half of all Medicare beneficiaries—39 million—were enrolled in a Part D plan.ⁱ

At the same time, however, the MMA severely limited the federal government's ability to control drug prices in the Medicare program. The MMA scaled back rebates offered by pharmaceutical companies for drugs provided to beneficiaries dually eligible for Medicare and Medicaid. Yet, under the Medicaid program federally determined rebates for pharmaceuticals still apply.

Restoring Medicaid-level drug rebates for low-income Medicare beneficiaries is one of several options available to secure significant savings in the Medicare program. Reinstating this discount, as reflected in the Medicare Drug Savings Act (S. 740 and H.R. 1588), would create considerable savings for the federal government—an estimated **\$141.2 billion over 10 years**.ⁱⁱ Nineteen Senators and over 30 members of Congress support this legislation. In addition, President Obama proposes restoring Medicare drug rebates in the Administration's 2017 budget request, and has consistently championed this common-sense solution in prior budget proposals.ⁱⁱⁱ

Our Position:

The Leadership Council of Aging Organizations (LCAO) recognizes the need to bring down the nation's deficit and reduce health care spending. With respect to Medicare, we support savings mechanisms that address system-wide health care inflation and build on the cost savings and efficiencies of the Affordable Care Act.

Unlike proposals that create federal savings by shifting costs onto beneficiaries, restoring Medicaid-level drug rebates for low-income Medicare beneficiaries meets our standard as a cost saving solution that works. We recommend that Congress restore drug rebate prices for Medicare beneficiaries who are dually eligible for Medicare and Medicaid and for beneficiaries with Extra Help.

Our Rationale:

Medicaid drug rebates translate into significant savings. A 2011 report by the House Committee on Oversight and Government Reform found that the cost of the top 100 drugs for dually eligible beneficiaries was 30% higher under Medicare than it would have been under Medicaid.^{iv} A 2012 analysis by the Department of Health and Human Services (DHHS) Office of Inspector General that compared the prices of 200 brand name drugs under Medicaid and Medicare Part D reached similar conclusions. The study finds that Medicaid rebates required by

law reduced expenditures by 47% for the drugs under review. In comparison, Part D rebates secured through negotiations with private plans reduced expenditures by only 15%.^v

Restoring Medicare drug rebates saves significantly more than proposals that merely shift costs.

The Congressional Budget Office (CBO) estimates that restoring Medicaid-level drug rebates for low-income Medicare beneficiaries saves an estimated \$141.2 billion over ten years.^{vi} These savings significantly dwarf those achieved by more harmful proposals that would shift costs to people with Medicare. For instance, the President’s proposal to increase Medicare Part B deductibles for newly eligible beneficiaries, beginning in 2020, saves only \$4.2 billion over ten years.^{vii}

Research and development by the pharmaceutical industry is not at risk. Preserving the pharmaceutical industry’s ability to innovate is often a top concern when considering altering drug prices and potentially diminishing industry profits. Studies show that research and development investments in particular types of drugs are not directly linked to specific revenue sources. These findings, coupled with an examination of PhRMA spending trends, suggests that reinstating Medicare drug rebates will not limit research and development.^{viii}

Costs for private purchasers—namely employers—will be largely unaffected. A 1997 RAND study examined how the “best price” formula for determining Medicaid drug rebates affects other private drug purchasers, such as employers. Under this rebate formula, the Medicaid program receives either the “best private price” for which a manufacturer sells a drug or a price 23.1% lower than the average manufacturer price, whichever is the lower of these. The 1997 study concluded that the Medicaid “best price” formula had a “small, but visible” effect on drug prices for other private purchasers. Yet, these small increases would amount to even less in today’s market given the increased use and availability of lower cost generic drugs.^{ix}

Claims that Medicare Part D premiums will rise for higher income beneficiaries are unfounded. Some stakeholders suggest that restoring Medicaid-level drug rebates for low-income Medicare beneficiaries would increase drug prices and Part D premiums for other beneficiaries in Part D. This argument is based on faulty reasoning. Research suggests that the negotiating power of Part D plans would not be compromised and that Part D drug prices and premiums would not be affected by restoration of the Medicaid-level drug rebates for a segment of the Medicare Part D population.^x

ⁱ Cubanski, J., & Neuman, T., “Medicare Part D at Ten Years: The 2015 Marketplace and Key Trends, 2006-2015,” (Kaiser Family Foundation, October 2015)

ⁱⁱ Office of Senator Jay Rockefeller, “Press Release: Rockefeller and 18 Other Senators Introduce Legislation to Protect Seniors & Reduce the Deficit by \$141.2 Billion,” April 2013, available at: <http://www.rockefeller.senate.gov/public/index.cfm/press-releases?ID=617fffeb-4c5a-4123-a5b3-1f8b790e5f8b>.

ⁱⁱⁱ U.S. Department of Health and Human Services, FY 2017 Budget in Brief: Strengthening Health and Opportunity for All Americans,” (2016) <http://www.hhs.gov/sites/default/files/fy2017-budget-in-brief.pdf>.

^{iv} “[67 House Members Urge Boehner to Include Medicare Drug Price Negotiation in Final Debt Reduction Deal](#)” – Letter to Speaker Boehner from Rep. Hinchey, Rep. Schakowsky, Rep. Sam Barr and Rep. Peter Welch (June 2011)

^v “Medicaid Rebates for Brand-Name Drugs Exceeded Part D Rebates by a Substantial Margin.” – Department of Health and Human Services – Office of the Inspector General (April 2015)

^{vi} Office of Senator Jay Rockefeller, “Press Release: Rockefeller and 18 Other Senators Introduce Legislation to Protect Seniors & Reduce the Deficit by \$141.2 Billion,” April 2013, available at: <http://www.rockefeller.senate.gov/public/index.cfm/press-releases?ID=617fffeb-4c5a-4123-a5b3-1f8b790e5f8b>.

^{vii} U.S. Department of Health and Human Services, FY 2017 Budget in Brief: Strengthening Health and Opportunity for All Americans,” (2016) <http://www.hhs.gov/sites/default/files/fy2017-budget-in-brief.pdf>.

^{viii} “[Prescription Drug Procurement and the Federal Budget](#).” –R. Frank, Kaiser Family Foundation (May 2012); “[Debunking Medicare Myths: Drug Rebates for Dual Eligibles](#).” – Center for Medicare Advocacy (2011)

^{ix} [“Prescription Drug Procurement and the Federal Budget.”](#) – R. Frank, Kaiser Family Foundation (May 2012)

^x [“The Medicare Part D Drug Rebate Proposal: Rebutting An Unpersuasive Critique.”](#) – R. Frank and J. Hoadley in Health Affairs Blog (December 2012)