HERB KOHL, WISCONSIN, CHAIRMAN

BOB CORKER, TENNESSEE, RANKING MEMBER

United States Senate

SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510–6400
(202) 224–5364

October 12, 2011

The Honorable Patty Murray
Co-Chairman
Joint Select Committee on Deficit Reduction
United States Congress
448 Russell Senate Office Building
Washington, DC 20510

The Honorable Jeb Hensarling
Co-Chairman
Joint Select Committee on Deficit Reduction
United States Congress
129 Cannon House Office Building
Washington, DC 20515

Dear Co-Chairmen Murray and Hensarling:

We can all agree on the need to significantly reduce federal spending in order to put our country back on a sound fiscal path. Your committee has a tremendously important task ahead of it—to reduce the federal deficit by $1.5 trillion. I commend you for your commitment to succeed with a bipartisan plan and I believe that we can find common ground on policies that will yield significant savings to the American taxpayers.

As Chairman of the Senate Special Committee on Aging, I am particularly focused on programs upon which older Americans rely each day. Within these programs, I have developed a range of policy options that would reduce federal spending by well over $140 billion. In accordance with Section 401(b)(3)(A)(ii) of the Budget Control Act, I ask that your committee thoroughly review and consider these recommendations and have the Congressional Budget Office (CBO) score them to quantify the savings for the American consumers and taxpayers.

Cost-Saving Policies

The following are eleven policy proposals, nine of which the Senate Special Committee on Aging considered during a July hearing on drug costs, "A Prescription for Savings: Reducing Drug Costs to Medicare." We hope that you will carefully consider each of these policy options.

1. Get generics to the market sooner by ending pay-for-delay settlements. The bipartisan Preserve Access to Affordable Generic Drugs Act (S. 27) would combat pay-for-delay settlements used to keep lower-cost generic drugs off pharmacy shelves. Under these pay-off agreements, brand name drug companies settle patent disputes by paying generic drug manufacturers for the promise of keeping its product off the market. The Kohl-Grassley bill seeks to stop this anti-consumer practice by presuming these deals illegal and giving the FTC the authority to challenge them in court. CBO estimates that this legislation would save taxpayers $2.68 billion over 10 years. The Administration's FY2012 Budget proposal includes a provision to end pay-for-delay settlements, and estimated savings of $8 billion over 10 years. The bill has eight cosponsors, Senators Sherrod Brown, Collins, Durbin, Franken, Grassley, Tim Johnson, Klobuchar and Sanders. The bill was passed out of the Judiciary committee on July 21, 2011.

2. Allow Medicare to directly negotiate prices of prescription drugs in Part D. The Prescription Drug Price Negotiation Act (S.44) would allow the negotiation of Medicare Part

D prescription drugs. Under Senator Klobuchar's legislation, the Secretary of Health and Human Services would be provided negotiation authority. The bill has eight cosponsors, Senators Begich, Blumenthal, Feinstein, Inouye, Johnson, Kohl, Sanders and Shaheen.

3. Require prescription drug manufacturers to provide discounted medications to low-income Medicare recipients. The Medicare Drug Savings Act (S. 1206) would increase the discounts Medicare receives on prescription drugs for low-income individuals enrolled in Medicare Part D. This policy would save Medicare $112 billion over the next ten years, reducing the federal deficit and strengthening Medicare. This legislation was introduced by Senator Rockefeller, and cosponsored by Senators Bingaman, Blumenthal, Boxer, Brown, Franken, Merkley, Stabenow, Leahy, Mikulski, Sanders, Tom Udall and Kohl.

4. Require drug manufacturers to pay rebates for Medicare Part B drugs. Medicare should require drug manufacturers to provide discounts for Medicare Part B. The Department of Health and Human Services Office of Inspector General (HHS OIG) found that if Part B received rebates similar to the Medicaid program for 20 high-dollar drugs, the Medicare program would have saved $1.9 billion to $2.4 billion in 2010 alone. Both the HHS OIG calculations and the policy proposal, which is included in the Prescription Drug Cost Reduction Act, are enclosed.

5. Allow Medicare to negotiate drug prices in Medicare Part B when it is the majority purchaser. Current law bars the Centers for Medicare and Medicaid Services (CMS) from negotiating the prices for physician-administered drugs within the Medicare Part B program, even when the government pays for the vast majority of a specific drug—sometimes over 90 percent. This policy would allow the federal government to negotiate with a pharmaceutical company when Medicare is the majority purchaser of its drug. The policy would end the practice of the federal government simply accepting any price set by a pharmaceutical company. This proposal is included in the Prescription Drug Cost Reduction Act, which is enclosed.

6. Allow CMS to pay the same price for drugs that are similar. For 15 years, Medicare used an authority called "least costly alternative" (LCA) to ensure that CMS, beneficiaries and taxpayers did not pay more for a drug when a similar, cheaper drug produced the same clinical result. Unfortunately, a recent court case ruled that CMS lacked the statutory authority to exercise LCA. This policy would provide CMS with the authority to use the LCA policy for pricing similar drugs in Medicare. A report by the HHS OIG estimated a savings of $40 million per year with the institution of an LCA for just two drugs used to treat prostate cancer – Lupron and Zoladex. When expanded to include more drug classes, the LCA policy can save even more money – without limiting access to the same life-saving drugs Medicare beneficiaries receive now. This policy proposal is included in the Prescription Drug Cost Reduction Act, which is enclosed.

7. Reduce incentives for doctors to prescribe high cost drugs over safe, effective and cheaper generic drugs. Currently, doctors receive a payment of 6 percent of the price of a drug administered to a patient under Medicare Part B. Existing law provides a strong incentive to use the most expensive, brand name drug available instead of the less expensive generic drug, and raises the cost of drugs for Medicare recipients, taxpayers, and the federal government. This proposed policy would create a more equitable payment structure for the

drugs and eliminates the disincentive to prescribe lower-cost, equally efficacious drugs. This policy proposal is included in the Prescription Drug Cost Reduction Act, which is enclosed.

8. Minimize costs by requiring transparency from Pharmacy Benefits Mangers (PBMs). By acting as the middlemen between insurers and drug companies, PBMs manage drug benefits for the federal government and most employers. PBMs negotiate drug prices, formularies and pharmacy payments for health plans. Drug companies often pay PBMs to promote their drugs within formularies and to increase the utilization of a drug—but PBMs may not disclose these payments to their clients. The payments can lead to higher drug costs for taxpayers and consumers. For example, Wisconsin saved over $150 million after switching to a more transparent PBM.[1] One Illinois report estimated a state savings of up to $140 million per year.[2] This policy would require PBMs to disclose payments received from drug companies to federal clients and would boost transparency and help to minimize costs. This policy proposal is included in the Prescription Drug Cost Reduction Act, which is enclosed.

9. Guard against the unnecessary prescription of dangerous and costly drugs for nursing home residents. This policy would require physicians to complete a written certification form before prescribing atypical antipsychotics for nursing home residents. In April 2005, the Food and Drug Administration (FDA) issued "black box" warnings against prescribing atypical antipsychotic drugs for patients with dementia, cautioning that the drugs increased dementia patients' mortality. According to a 2011 Office of Inspector General (OIG) report, nearly 1.4 million Medicare claims for atypical antipsychotic drugs were prescribed off-label for elderly nursing home residents costing taxpayers hundreds of millions of dollars for these drugs over a six-month period. This policy proposal is included in the Prescription Drug Cost Reduction Act, which is enclosed.

10. Expand a current drug discount program (340B) to PACE plans. This policy would allow the federal integrated care program for dually eligible beneficiaries, PACE (Program of All-Inclusive Care for the Elderly) to directly purchase pharmaceuticals through the "340B" program, which is used by Community Health Centers to purchase drugs. The program provides drugs at a much lower cost than Medicare and, in some cases, at costs lower than Medicaid. This policy is structured so that most of the savings would be realized by Medicare, with a portion available for PACE plans meeting certain requirements. This proposal is included in the Prescription Drug Cost Reduction Act, which is enclosed.

11. Close tax loopholes related to life settlement transactions.
In the last several decades, there has been a rapid increase in life settlement transactions, whereby individuals sell their life insurance contracts to investors who receive the death benefit when the policyholder dies. The Government Accountability Office (GAO) estimates of the total value of policies settled in 2008 ranged from $9 billion to $12 billion. It is critical

---

[1] Statement of Rep. Sharon Anglin Treat. House Oversight and Government Reform Hearing on H.R. 4489, FEHBP Prescription Drug Integrity, Transparency & Cost Savings Act. February 10, 2010. http://www.reducedrugprices.org/av.asp?na=594

[2] http://www.ilga.gov/commission/cgfa2006/Upload/PharmacyBenefitCost0406.pdf

to update reporting requirements to ensure compliance with current tax law. This proposal is included in the Administration's budget options and would reduce the deficit by nearly $1 billion over 10 years.

Finally, I strongly urge the Joint Select Committee on Deficit Reduction ("Joint Committee") to avoid changes to Social Security. While I believe that improvements need to be made to strengthen the program and ensure it is on a solvent path for future generations, I do not believe that fiscally reforming Social Security should be used to offset other federal priorities. In its 76 year history, Social Security has never contributed to our federal deficit, and is statutorily barred from doing so. The changes needed to make the program sustainable are relatively small and achievable if done in the near term, and I am committed to modernizing this important program for future generations once the Joint Committee's work is completed.

Thank you for your consideration of these proposals. During your deliberations, my staff and I would be happy to answer any questions and serve as a resource. We look forward to working with you and wish your panel success in its mission.

Sincerely,

Herb Kohl
Chairman

Enc:
HHS OIG Report
Prescription Drug Cost Reduction Act

CC:
Senator Max Baucus
Senator John Kerry
Senator John Kyl
Senator Rob Portman
Senator Pat Toomey
Congressman Xavier Becerra
Congressman Dave Camp
Congressman James Clyburn
Congressman Fred Upton
Congressman Chris Van Hollen