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Mr. Chairman and members of the Senate Finance Committee thank you for inviting me to testify this morning. I am Gerard Anderson a professor of Health Policy and Management, Professor of International Health and Professor of Medicine at Johns Hopkins University.

Brief Summary

There is evidence that Part D plans are paying higher rates for certain drugs than the VA, Medicaid, or Canada are paying for these same drugs. Congress should require the Secretary of HHS to compare prices at the individual drug level and negotiate when the Part D plans are paying more than the VA, Medicaid or Canada.

Overview Of Testimony

Let me begin by stating that I believe in markets. Now let me qualify that statement. I believe in markets if certain circumstances are met. Some of the circumstances that can cause market failure are discussed in my testimony. Unless those circumstances are met there can be distortions in the market or even market failure. Much of the debate and legislation involving the Senate Finance Committee involves issues of market distortions and market failure in various industries and very commonly in health care.

My suggested approach has several parts. As a first step the Congress should repeal the non interference clause and require the Secretary of HHS to compare the lowest prices that any Part D plan obtains to the prices obtained by the VA, Medicaid, and Canada.

The Secretary should then compare the lowest price obtained in the market place to the VA price because the VA Secretary has negotiated these drug prices with pharmaceutical companies. Medicaid prices are an appropriate comparison because this government program has been operating for many years and have an extensive formulary. Canada's prices are a relevant comparison because it will show what other countries are paying for drugs. Also, if there is a large differential between the Canadian and US prices for drugs this will cause a substantial number of American seniors to obtain drugs from Canada.

The report by the Secretary will compare the relative prices for the VA, Medicaid, Canada and the lowest price the Part D plans were able to obtain in the market place. As I said earlier, I believe in markets but as Ronald Reagan said – Trust but Verify**.** This report will verify when the market is working and where there is market failure**.**

Without access to the data on the price obtained by the Part D plans, it is impossible to compare the prices received by Part D plans to prices obtained by the VA, Medicaid or Canada. However, based upon available data it is possible to anticipate some of the findings. I will explain why and estimate the impact in the report that follows.

First, it is likely that the prices for generic drugs will be comparable or even lower in Part D plans.

Second, prices for drugs used by dual eligibles are likely to have increased from what Medicaid paid for the same drugs. With the passage of the Medicare Modernization Act, responsibility for drug coverage for dual eligibles was transferred from the Medicaid program to the Medicare program. Drug prices for dual eligibles are now determined by a negotiation between the pharmaceutical companies and the Part D plans. It is likely that Part D plans are paying substantially higher prices than the Medicaid program used to pay for drugs used by the dual eligibles. Because the Medicare program provides drug coverage by the dual eligibles, it is the Medicare program that is paying these higher drug prices.

Third, it is likely that the Secretary's report will show that the Part D plans are paying higher rates for many brand name drugs. This is because there are several market constraints that interfere with a functioning market for brand name drugs.

With this data the Secretary of HHS can begin to negotiate with the pharmaceutical industry. My recommendation is that the Secretary start with the drugs where the market prices are highest compared to what the VA, Medicaid and Canada pay for the same drugs and work down the list. Assume for a moment that the lowest prices that any of the Part D plans could obtain for drug A is $10.00 and the VA, Medicaid and Canada were all paying approximately $1.00 for that same drug. In this case the Secretary could begin by simply asking the pharmaceutical company why it is charging the Part D plans 10 times more and then take additional steps if necessary. The VA, Medicaid directors and other countries have been engaging in this dialogue with pharmaceutical companies for years. Two Congressional Research Services Reports detail the approaches that have been taken. It is important to recognize that these approaches have been taken without large bureaucracies and there is no reason to believe that CMS could not be equally efficient.

It is sometimes suggested that because the Medicare program is such a large payor for drugs that it must pay higher prices than the VA, Medicaid, or Canada. I find problems with that logic as well. First, large purchasers seldom pay the highest prices. Second, the federal government is already supporting pharmaceutical research through the NIH. Third, Medicare beneficiaries should not be asked to pay the highest prices and Medicare beneficiaries should not be the primary supporter of pharmaceutical research and development in the world when other payors and other industrialized countries benefit.

Like the story of *Goldilocks* and the *Three Bears* I am looking for the "just right" solution. Some editorials have suggested that the Secretary will be too aggressive while other editorials have suggested that the Secretary will be ineffective. Surprisingly, some editorials have made both arguments in the same editorial.

Some editorials have proposed that the Secretary will be an ineffective negotiator because the Secretary cannot restrict the formulary. Under my proposal the Secretary would

negotiate prices only for drugs where the market place is already paying relatively high prices.

Some editorials have argued that the Secretary will be such an effective negotiator that the low prices will stifle pharmaceutical research and development. However, because the pharmaceutical companies have already accepted the prices at the VA, Medicaid and Canada this should be an acceptable starting point for negotiations.

In my opinion the “just right” solution is to have the Secretary identify the drugs where the Part D plans are paying much higher prices and have the Secretary negotiate prices for those drugs to make sure the Medicare program and Medicare beneficiaries are getting a good deal. This will require that Congress repeal the non interference clause, mandate that the Secretary of HHS examine the prices that the market place is getting relative to other entities, and negotiate when the market has failed.

Begin By Collecting The Facts

It is fine to believe in markets. However, there are times when markets do not work. Congress should tell the Secretary of HHS to find out when the market is working by mandating that the Secretary collect comparative price data.

As a first step, the Secretary of Health and Human Services should identify the lowest price that any of the Part D plans were able to obtain from the pharmaceutical companies. It is likely that one Part D Plan will have obtained the lowest price for one drug while another Part D Plan will have obtained the lowest price for another drug. All that should be included in the Secretary's report is the lowest price that any Part D Plan was able to obtain for each drug. The Secretary's report would not disclose the price that each Part D plan paid or the name of the Part D plan that paid the lowest price. It represents the lowest price the market place could obtain. The price should include all discounts, price concessions and rebates.

This information is currently not available on www.Medicare.gov. The prices on www.Medicare.gov reflect the prices that Medicare beneficiaries pay for the drugs and not the purchase prices of the Part D plan. They do not include the price concessions, rebates, or discounts the Part D plans receive.

Congress should then require the Secretary to prepare a semi-annual report that compares the lowest price that any of the Part D plans obtain to the prices obtained by the VA, Medicaid program, and Canada for each drug. It will show where the market is working and where there is market failure. A recent Congressional Research Service Report and a 2005 Congressional Budget Office Report details how these various organizations establish the drug prices.

It is important to compare the drug prices received by other government programs. The VA is an appropriate comparison because the VA Secretary negotiates prices with the pharmaceutical industry and receives the best prices. Medicaid prices are an appropriate comparison because the Medicaid directors are a government program that has been paying for drugs for many years. Canada is an appropriate comparison because it is a government entity that pays for drugs. More important, if the price differential between US and Canadian prices is large, then millions of seniors will go to Canada to obtain drugs.

It is important to compare the prices at the individual drug level since the market place will be more competitive for certain drugs than for other drugs. With this information the Secretary of Health and Human Services will be able to compare the lowest prices that are obtained in the market place to other prices. This will give the Secretary the necessary information to determine where the market place is effective and where negotiation is needed.

The Facts That Are Available About Comparative Prices

Unfortunately we do not know the prices that the Part D plans are paying for individual drugs. CMS collects the data on prices, price concessions, rebates, and discounts but is prohibited by the MMA from sharing this data or even analyzing it internally. As a result, no one knows the rebates, price concessions or discounts that the Part D plans receive. The MMA prevents CBO, GAO, CRS and university researchers from obtaining this data. Fortunately there is some data that compares the prices Part D plans are getting to the prices obtained by the VA, Medicaid and Canada.

In 2004, I coauthored a paper that was published in the peer reviewed journal Health Affairs. In the paper we compared the prices for the 30 most commonly sold drugs in the United States to the prices for the same drugs in Canada, the United Kingdom and France in 2003. What we found was that the United States was paying substantially higher prices for the market basket of the 30 most commonly prescribed drugs. We assumed that the private sector would obtain a 20% reduction from the average wholesale price (AWP). We then calculated that the United States consumer was paying 52% more than people in the United Kingdom, 67% more than people in Canada, and 92% more than people in France for the market basket of 30 drugs. Comparisons are necessary drug by drug and dose by dose.

However, we also found that the markups were not uniform across the 30 drugs. This illustrates why it is important to analyze the relative prices for each individual drug. Table 1 compares the prices in the US to the prices in the other countries for each of the 30 drugs. For example, in 2003, 10 doses of Lipitor cost 36% more in the US than Canada, 86% more than in France and 65% more than in the UK. 20 doses of Zocor cost 42% more in the US than Canada, 190% more than in France, and 69% more than in the UK. Sometimes the US gets the lowest price (Viagra) and in most cases the US pays the highest price. Also note that some drugs are not sold at certain doses in certain countries. Price variations exist between the US and the other countries for all 30 drugs and there is even considerable variation in the relative prices for the same drug by dose.

In developing S2354, Senator Nelson from Florida asked me to perform the same analysis using the VA as the comparison group. The empirical results were remarkably similar to the earlier findings in the Health Affairs article. It appears that the VA is paying approximately the same prices as Canada, France and the United Kingdom. In 2006, I presented these findings in two hearings conducted by the Democratic Policy Committee chaired by Senator Dorgan.

In June 2005, the Congressional Budget Office prepared a report that compared the prices for “brand name” drugs that were obtained by different federal agencies in 2003. The report compared the discount that various federal agencies received to the average wholesale price (AWP). Average wholesale price is the “publicly available, suggested list price for sales of drugs by a wholesaler to a pharmacy of other providers.” CBO selected the average wholesale price “as the reference price for the analysis because it is commonly used in pharmaceutical transactions”. It should be noted that the pharmaceutical companies will often provide discounts, rebates, and other price concessions and so the average wholesale price is not the actual price the wholesalers pay. It is also not the price that most patients pay.

Price Comparisons

CBO estimated that average price paid by the Medicaid program was 51% of average wholesale price and the VA paid 42% of the average wholesale price. Both the VA and Medicaid have price lists that could be easily be compared to the lowest prices that any Part D plan is able to obtain. Canada also has a price list although each province has a different price list.

Because of provisions in the Medicare Modernization Act data on the actual prices that Part D plans pay is not publicly available. In order to estimate the actual prices paid by the Part D plans, it is necessary to rely on the numbers produced by the CMS actuaries. In their report (Table 2) on the projected costs in the Part D program, the CMS actuaries assume a 21 percent reduction in average wholesale price and a 6 percent rebate for a total of 27 percent reduction from the average wholesale price (Table 2). In other words, the CMS actuaries assume that the Part D plans pay 73% of the average wholesale price.

First, it should be noted that the reduction the CMS actuaries estimate is considerably less than what the VA or Medicaid have obtained. The 73% number is comparable to the 51% number of the Medicaid program and 42% number by the VA.

Second, it is important to notice in Table 2 that the CMS actuaries do not anticipate that the Part D plans will become any more effective over the years in negotiating price reductions from the pharmaceutical companies. They do not anticipate that market forces will continue to lower prices over time. In the CMS projections, the discounts are constant over the years from 2006 to 2015.

Who Benefits From Price Transparency in Drug Pricing

Two groups will benefit from having greater drug price transparency – Medicare beneficiaries and the Medicare program.

Because drugs are sold under the same name to all purchasers, a Medicare beneficiary can compare the VA, Canada, and Medicaid prices to the price that the drug store is charging. Because they will know the drugs they are purchasing at that moment they will be able to do the price comparison. Medicare beneficiaries in the “doughnut hole” pay retail prices and they should know the relative prices since they purchase the drugs out-of-pocket while they are in the “doughnut hole.”

The Medicare program also benefits from price transparency. The Medicare program pays the full bill for millions of low income beneficiaries. The Medicare program should be monitoring drug prices to make sure that it is getting the best prices for drugs for these beneficiaries. Otherwise, the government is spending money unnecessarily. As will be shown in the next section, the Medicare program pays higher drug prices for dual eligibles than the Medicaid was paying for the same drugs for the same dual eligibles.

Likely Areas of Negotiation

Without data on the actual prices that the Part D plans are paying for drugs, I cannot say exactly which drugs will have the highest price differentials compared to the VA, Medicaid, or Canada.

However, the limited available data does suggest that the Medicare program is paying more for dual eligibles than the Medicaid program paid. The data also suggests that the Part D plans are likely to be paying higher prices for certain “brand name” drugs. Part D plans are probably getting reasonable prices for most generics.

The available data suggests that the private sector is likely to obtain reasonably good rates for generic drugs. Wal-Mart has just announced a list of drugs that it will sell for $4.00 and

other retailers are matching prices. A study conducted by Professor Patricia Danzon from the Wharton School of Business published in Health Affairs suggests that prices for generic drugs may be lower in the United States than they are in many other counties because the price competition for generics is greater in the United States.

My expectation is that Secretary of HHS would find that the prices obtained by the Part D plans for generics would be comparable to those at the VA, Medicaid and lower than in Canada. If this is the case, the Secretary probably would not choose to negotiate on generic drugs and allow the marketplace to operate.

Dual Eligibles

According to data from the CBO and CMS actuaries, the rates that the private sector is paying for "brand name" drugs is higher than the rates paid by Medicaid. The Medicare Modernization Act moved millions of dual eligibles from Medicaid to Medicare for prescription drug coverage. Because the Part D plans are paying substantially higher rates than Medicaid used to pay for the same drugs for the dual eligibles, the amount that the Medicare program ends up paying for drugs for the dual eligibles has increased substantially.

One simple way to estimate the increased payments that the Medicare program is making is to compare the rates that CBO estimates that Medicaid and the private sector pay for "brand name" drugs. According to the CBO report, the average manufacturer price is 79% of the average wholesale price. The average manufacturer price is the "average price paid to a manufacturer for drugs distributed through retail and mail-order pharmacies". The CMS actuaries' then subtract an additional 6% discount for rebates. This suggests that the private sector is paying 73% of average wholesale price. However, Medicaid was paying only 51% of average wholesale price. This suggests that Medicare is paying substantially more than Medicaid for the same drugs for the same dual eligibles. There is collaborating evidence from the pharmaceutical companies own reports to the financial industry.

Pharmaceutical companies are required to file 10Ks and 10Qs with the Securities and Exchange Commission whenever a major event occurs that could influence the stock price. There are indications in some of the 10Ks and 10Qs filed by the pharmaceutical companies that they are getting higher prices from Medicare than they did from Medicaid. For example, in its 10Q report dated October 1st 2006, Pfizer acknowledged that additional they paid fewer rebates, price concessions and gave fewer discounts due "to the impact of the Medicare Act". On page 34 of their report, Pfizer states that "Our accruals for Medicaid rebates, Medicare rebates, contract rebates and charge backs totaled $1.5 billion as of October 1, 2006, a decrease from $1.8 billion as of December 31, 2005, due primarily to the impact of the Medicare Act".

Brand Name Drugs

Negotiation may be necessary for certain "brand name" drugs. The specific drugs that will be subject to negotiation will depend on the data collected by the Secretary of HHS. Where there is a large difference between the lowest price determined by the market and the prices obtained by Medicaid, the VA or Canada, the Secretary should consider a series of actions.

Will Negotiations Be Necessary?

As noted earlier, it is unlikely that negotiations will be necessary for many drugs. The market place will be able to obtain a reasonable price for many drugs. For some drugs, however, negotiation may be necessary.

My recommendation is that the Secretary start with the drugs where the market prices are highest compared to the VA, Medicaid and Canadian price and work down. Assume for a moment that the lowest prices that any of the PDPs could obtain for drug A is $10.00 and the VA, Medicaid and Canada were all paying approximately $1.00 for that same drug. In this case the Secretary could begin by simply asking the pharmaceutical company why it is charging the Part D plans 10 times more and then take additional steps if necessary.

Medicaid directors and the VA have been engaging in this dialogue with pharmaceutical companies for years. Secretary Thompson recently negotiated a price discount for CIPRO following the anthrax scare. The Congressional Research Service recently prepared a report detailing how the VA and Medicaid program determine the rates they pay. Another Congressional Research Service Report details the approaches taken by other countries. The Secretary should review these options and proceed accordingly.

It is important to recognize that these programs have developed prices without large bureaucracies.

Bully Pulpit

It is possible that having the Secretary of HHS simply conduct the price comparison and report the drugs where the Part D plans are paying much higher prices will alter the market sufficiently. Drugs companies will not want to have to explain large price disparities to the Secretary or to the public.

Without some type of intervention it is important to note that CMS actuaries do not expect drug prices to continue to fall under current law according to the data presented in Table 2. The Secretary's bully pulpit could cause additional price reductions in the market place.

Formularies

One concern that has been expressed repeatedly in editorials and newspapers is that the Secretary will not be able to negotiate as effectively because nearly all drugs will have to be on the Medicare formulary. This is because each of the Part D plans has their own formulary and the Medicare program would have to accommodate the formularies of all the Part D plans.

This would be true if the Secretary tried to negotiate prices for each and every drug. However, the Secretary of Health and Human Services is negotiating prices only for those drugs where the Part D plans have been unable to obtain prices comparable to Medicaid,

VA, and Canada. The Secretary of HHS should intervene only when the relative prices are high and there is market failure. In these cases I expect the Secretary will be an equally effective negotiator as the Medicaid directors.

Administrative Costs

It has been suggested that CMS will need to greatly expand the bureaucracy in order to negotiate prices. Medicaid programs, the VA, Canada, and the Part D plans have been able to negotiate rates with minimal bureaucracies.

Because the Secretary of Health and Human Services would need to negotiate rates only for those drugs where the prices paid by the Part D plans are much higher than the rates in the VA, Medicaid, and Canada, the number of negotiations would be relatively few. Fewer staff would be needed than if the Secretary were trying to negotiate prices for each drug.

Goldilocks Arguments

I now return to the *Goldilocks* arguments that have been proposed. Sometimes the editorials argue that the Secretary will be too aggressive and sometimes the Secretary will be ineffective. Surprisingly both arguments have been made in the same editorial.

One argument is that the Medicare program will set the price too low and this will stifle pharmaceutical research and development. However, the pharmaceutical companies already have voluntarily signed contracts with the VA, Medicaid and Canada. While the pharmaceutical companies need to have prices that should allow them sufficient resources to fund research and development, it is not appropriate for the Medicare program and Medicare beneficiaries to be paying a large portion of the world's pharmaceutical research and development costs. Second, only a small portion of the drug company spending is actually for research and development. Pharmaceutical companies spend more on marketing than they do on research and development. Finally, the federal government recently doubled its investment in NIH to foster biomedical research and development and this investment should defray some of the cost of pharmaceutical development.

An opposing argument is that the rates will be too high because the Part D plans can negotiate more effectively than the Secretary. If this is the case then the Secretary of Health and Human Services will not have to negotiate for many drugs because the data will show that the Part D plans have obtained the lowest prices from the pharmaceutical companies.

The argument is made that Medicare can not negotiate effectively unless the Secretary is willing to walk away and not include a drug in the formulary. However, for many years state Medicaid programs have paid lower prices for drugs than the Part D plans have been able to obtain for the "dual eligibles." So have VA Secretaries and there is no also evidence that VA patients are suffering clinically because of the formulary in the VA.

The pharmaceutical industry is paying for advertisements citing a Kaiser Family Foundation study showing the most Americans are satisfied with the Medicare Part D plan. What these advertisements do not mention is that 67% of the public strongly favors and another 14 % somewhat favors "allowing the government to negotiate with drug companies for lower prices for Medicare RX drugs" Negotiating with drug companies has strong public support.

The bottom line is that Medicare beneficiaries often pay the highest drug prices in the world and it is the Medicare beneficiaries and the Medicare program that suffers.

Summary

In summary, I think that the Secretary should collect price data on every drug and then compare the lowest private sector price to the prices paid by the VA, Medicaid, and Canada. With this information the Secretary can determine where the differentials are the greatest and where negotiation is needed. The Congress should repeal the non interference clause and give the Secretary of HHS the authority to negotiate prices in circumstances where the Part D plans cannot get reasonable prices.

Table 1 Comparing US Prices to Canada, UK, and France for the 30 Most Commonly Prescribed Drugs in the US in 2003				
Product	Dose	US: Canada	US: France	US:UK
Lipitor	10	1.36	1.86	1.65
Lipitor	20	1.64	.	1.49
Lipitor	40	1.63	1.41	2.13
Lipitor	80	1.67	1.89	1.64
Zocor	20	1.42	2.90	1.69
Zocor	40	1.80	1.79	1.75
Zocor	10	1.00	.	1.30
Zocor	80	1.27	.	1.24
Zocor	5	1.46	1.78	.
Prevacid	30	1.59	.	.
Prevacid	15	1.47	.	.
Paxil	20	1.60	2.48	2.07
Paxil	40	.	.	.
Paxil	10	1.62	.	.
Paxil	30	1.52	.	1.21
Zoloft	100	1.45	.	1.21
Zoloft	50	1.27	1.96	1.62
Zoloft	25	3.41	2.56	.
Celebrex	200	2.29	2.06	2.14
Celebrex	100	2.95	2.65	2.75
Celebrex	400	.	.	.
Norvasc	5	0.96	1.58	1.26
Norvasc	10	1.09	2.63	1.46
Norvasc	2.5	.	.	.
Neurontin	300	1.21	1.38	1.08
Neurontin	100	1.29	1.86	1.09
Neurontin	400	1.24	1.42	1.12
Neurontin	600	1.13	1.36	0.89
Neurontin	800	1.03	1.32	0.94
Effexor	75	1.23	.	1.27
Effexor	37.5	1.94	2.75	1.69
Effexor	25	.	4.08	.
Effexor	100	.	.	.
Effexor	50	.	2.76	1.22
Pravachol	40	2.00	1.93	1.93
Pravachol	20	1.45	2.00	1.16
Pravachol	10	1.74	.	2.15
Pravachol	80	.	.	.
Vioxx	25	2.46	1.73	1.76
Vioxx	12.5	2.07	1.60	1.59
Vioxx	50	.	.	.

Table 1 Comparing US Prices to Canada, UK, and France for the 30 Most Commonly Prescribed Drugs in the US in 2003 (Continued)				
Fosamax	70	1.68	1.22	1.22
Fosamax	35	.	.	.
Fosamax	10	1.24	1.34	1.25
Fosamax	5	1.62	1.32	1.18
Fosamax	40	1.50	.	.
Wellbutrin	75	.	.	.
Wellbutrin	100	2.39	.	.
Zithromax	250	1.59	2.03	1.61
Zithromax	600	1.40	.	.
Zithromax	500	.	.	1.71
Zithromax	1000	.	.	.
Zithromax	250	.	.	.
Singulair	10	1.32	1.42	1.41
Singulair	5	1.97	1.44	1.43
Singulair	4	2.13	.	1.39
Ambien	10	.	9.62	9.01
Ambien	5	.	.	9.98
Levaquin	500	2.02	.	.
Levaquin	250	2.00	.	.
Levaquin	750	.	.	.
Viagra	100	0.89	0.78	0.78
Viagra	50	0.89	0.93	0.95
Viagra	25	0.93	0.99	1.04
Premarin	0.63	6.27	3.39	3.28
Premarin	1.25	5.16	2.85	3.63
Premarin	0.3	5.36	.	.
Premarin	0.9	4.18	.	.
Premarin	2.5	.	.	5.71
Claritin	10	3.64	5.43	5.37
Augmentin	875	2.95	.	.
Augmentin	500	3.46	4.13	.
Augmentin	250	2.54	3.17	.
Toprol	50	2.99	.	9.10
Toprol	100	2.66	1.21	8.34
Toprol	25	.	0.79	.
Toprol	200	4.29	2.27	5.60
Synthroid	0.08	5.70	.	.
Synthroid	0.1	6.65	.	.
Synthroid	0.05	8.84	.	.
Synthroid	0.13	6.68	.	.
Synthroid	0.15	7.98	.	.
Synthroid	0.03	4.94	.	.
Synthroid	0.11	5.84	.	.

Table 1 Comparing US Prices to Canada, UK, and France for the 30 Most Commonly Prescribed Drugs in the US in 2003 (Continued)				
Synthroid	0.2	8.55	.	.
Synthroid	0.18	6.84	.	.
Synthroid	0.3	6.34	.	.
Ortho-tri-cyclin	0	2.98	3.19	.
Allegra-D	60	3.02	.	.
Glucotrol	10	.	1.61	.
Glucotrol	5	.	1.68	.
Glucotrol	2.5	.	.	.
Zestril	20	2.74	0.99	1.12
Zestril	10	1.11	.	1.22
Zestril	40	.	.	.
Zestril	5	1.41	2.81	1.55
Zestril	30	.	.	.
Zestril	2.5	.	.	1.34
Amoxicillin	500	.	0.72	0.74
Amoxicillin	250	.	.	0.70
Amoxicillin	875	.	.	.
Atenolol	50	.	0.32	0.66
Atenolol	25	.	.	0.74
Atenolol	100	.	0.29	0.99
Flonase	---	2.41	3.90	2.36

Table 2

Key Factors for Part D Expenditure Estimates

Calendar Year	Annual Per Capita Drug Cost Increase	Cost Management and Discounts	Manufacturer Rebates	Plan Administrative Expenses
		Intermediate estimates		
2006	7.1%	21.0%	6.0%	12.5%
2007	7.2	21.0	6.0	11.8
11.9	7.3	21.0	6.0	11.9
2009	7.4	21.0	6.0	11.6
2010	7.5	21.0	6.0	11.5
2011	7.5	21.0	6.0	11.3
2012	7.6	21.0	6.0	11.1
2013	7.7	21.0	6.0	10.9
2014	7.7	21.0	6.0	10.7
2015	7.7	21.0	6.0	10.4

Source: CMS Actuaries