Executive Summary

Enacting legislation that will enable implementation of the National Retiree Legislative Network's (NRLN) Prescription Drug Cost Reduction Proposals can reduce the cost of Medicare and the U.S. deficit while increasing disposable income, thus infusing savings dollars into the economy without raising taxes.

The Global Market for Prescription Drugs - A Ten 10-Year View: Prescription drug sales were $307 billion in 2010, up 2.3% from 2009. Medicare sales were $62 billion. The IMS Institute for Healthcare’s May 2012 report quoted 2011 global and North American sales at $942 and $346 billion respectively, up 5.1%. U.S total sales for 2011 were $319 billion, up 4.2%. Medicare sales were $67 billion in 2011.

The Center for Medicare Services (CMS) 2012 “National Health Expenditure Projections” report estimated that U.S. Medicare prescription drug prices would rise 2.9% in 2012, 2.4% in 2013, 8.8% in 2014 (includes new participants added by the Affordable Care Act) but rises at an annual average of 6.6% from 2015-2021.

Unfortunately, there were cost solutions that could have been implemented in the 2003 Medicare Modernization Act (MMA) but weren’t; prescription drug industry manufacturers successfully lobbied against them. As an industry, prescription drug manufacturers have a reputation for complaining about high R&D costs and the pain of having to pay for high marketing and sales costs. They have asserted that imported drugs are unsafe and they lobby the FDA and Congress for protection. Other industries that are exposed to equal or greater competitive risks have not been granted protection from global competition. Despite the industry’s rationale for charging high costs, a Kaiser Family Foundation and Sonderegger Research Center report covering 1995-2009 shows that prescription drug companies somehow manage to eke out after-tax net profit as a percent of revenue that is more than triple the average after-tax net profit percentage of the average of all Fortune 500 companies.

The NRLN supports the importation of prescription drugs in a manner which is safe and under the oversight of the FDA. In 2009, only 10% of active drug ingredients and 11% of the generic drugs bought in the U.S. were manufactured in the U.S. Americans pay prices 3 to 20 times what U.S. manufacturers charge in other countries, shifting an unfair amount of U.S. drug company R&D and foreign market entry costs to Americans. The FDA operates a global complex of facilities and a staff of thousands who audit for compliance with FDA safety standards at U.S. and foreign-owned plants worldwide. The FDA has been asked by Congress to develop a resource plan that would ensure the safe offshore manufacturer of imported prescription drugs. The FDA does inspect some foreign manufacturing plants but has not created a plan to safely manage the increasing demand for importation of prescription drugs.

The NRLN estimates that a well-managed importation plan for prescription drug ingredients and finished products would save U.S. consumers 5% of the $4.7 trillion in total U.S. drug expenditures over the 2012-2021 ten-year period, a savings of $235 billion. Medicare savings would be 5% of $978.9 billion or $48.9 billion over the same period.
NRLN also supports competitive bidding for prescription drugs in Medicare. Medicare competitive bidding should be encouraged for more than just when generic drugs can compete with name brand drugs whose patents have expired. A looming danger is that today’s brand manufacturers are a rapidly growing segment of the generic manufacturing business and are capturing market share but also want to hang onto profit margins that are 3 to 4 times the average of Fortune 500 companies. Unless Congress authorizes Medicare to require head-to-head bids from generic manufacturers for Medicare’s generic business, generic prices will rise rapidly.

The NRLN supports competitive bidding for Medicare business and estimates that competitive bidding would reduce prescription drug costs for combined Medicare and non-Medicare payments over the 2012-2021 periods and save U.S consumers a minimum of 5% of $4.7 trillion, or $235 billion over the 2012-2021 periods. Medicare savings would be 5% of $978.9 billion or $48.9 billion over the same period.

The Case for Breaking the Generic Drug Log Jam: In 2006, there was a 5.5-year FDA generic drug application backlog. Congress recently passed an amendment allowing manufactures of generic drugs to pay FDA user fees that previously were only be paid by brand manufacturers. While these fees may cover a portion of generic manufacturer approval costs, the FDA must also staff adequately to anticipate ongoing growth of generic applications and to support safety and approval of globally-manufactured and imported ingredients and prescription drugs, should a law be passed. Adequate staffing would ensure that approval backlogs could be reduced to below six months on an ongoing basis.

The NRLN estimates that adequate FDA funding and staffing will increase the capability to accelerate generic drug approvals, improve efficiencies and rules that will create an even playing field for generic drug manufacturers. This would save U.S. Consumers 3% of $4.7 trillion or $141 billion over the 2012-2021. Medicare savings would be 3% of 978.9 billion or $29.4 billion over the same period.

Brand and Generic Drug Manufacturing Restraint of Trade: Payments to generic manufacturers by brand companies whose patents are expired are made in exchange for a pledge to stay out of the marketplace for a prescribed period of time. Today, “pay-for-delay” or "reverse payments" exist despite strong FTC opposition to the practice. In late 2012, the Philadelphia 3rd Circuit court ruled that pay-for-delay resulted in restraint of trade. The case remains in litigation. Congress shouldn’t wait for the Supreme Court; consumers need protection now.

Preventing anti-competitive practices will save U.S. consumers 1% of $4.7 trillion or $47 billion in the prescription drug spending over the 2012-2021 time period. Medicare savings would be 1% of $978.9 billion or $9.8 billion over the same period.

SUMMARY: If Congress enacts legislation to implement these proposals, it would save U.S consumers 14% of $4.7 Trillion or $657.3 billion in the projected U.S. prescription drug costs over the 2012-2021 time period. Medicare would save 14% savings on $978.9 billion or $137.1 billion over the same period. This $137.1 billion in Medicare savings equates to 2.9% of the $4.7 trillion in total U.S. prescription drug sales.

<table>
<thead>
<tr>
<th>Prescription Drug Proposal Savings 2012-2021</th>
<th>$ Savings</th>
<th>% Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Importation Savings</td>
<td>$235 billion</td>
<td>5%</td>
</tr>
<tr>
<td>Competitive Bidding Savings</td>
<td>$235 &quot;</td>
<td>5%</td>
</tr>
<tr>
<td>Generic Drug Expected Savings</td>
<td>$141 &quot;</td>
<td>3%</td>
</tr>
<tr>
<td>Elimination of Pay-For-Delay Savings</td>
<td>$ 47 &quot;</td>
<td>1%</td>
</tr>
<tr>
<td>TOTAL SAVINGS on $4.7 Trillion Sales</td>
<td>$657</td>
<td>14%</td>
</tr>
<tr>
<td>Medicare Savings Included</td>
<td>$137</td>
<td>14%</td>
</tr>
</tbody>
</table>
Prescription Drug Cost Reduction Proposals

A Call for Action

January 25, 2013

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I. The Prescription Drug Market

In April 2011, the IMS Institute for Healthcare reported 2010 spending on prescriptions drugs in the U.S. was $307.4 billion, up from $300.3 billion in 2009; an increase of $60 billion since 2005 and $135 billion since 2001. The volume of retail prescriptions dispensed totaled 4 billion, up from 3.2 billion in 2001.

Chart: Spending on Medicines Reached $307.4 Billion in 2010, Up 2.3% From 2009
IMS’s May 2012 report quoted global and North American sales at $942 and $346 billion respectively, up 5.1% over 2010. U.S sales for 2011 were $319.9 billion, up 4.2%. Medicare sales were $66.7 billion.

Medicare Part D beneficiaries filled 871 million prescriptions in 2010, accounting for nearly 22% of all prescriptions filled. Part D accounted for approximately 11% of Medicare's $523 billion budget in 2010 and Part D benefits were reported at $66.7 billion for 2011.

The Center for Medicare Services (CMS) 2012 “National Health Expenditure Projections” report estimates that U.S. Medicare prescription drug prices will rise 2.9% in 2012, 2.4% in 2013, 8.8% in 2014 (ACA) but then will rise an average of 6.6% 2015-2021.

According to the Agency for Health Care Research and Quality, the percentage of the U.S. population with a prescription drug expense in 2008 was 58% for those under age 65 and 90% for those 65 and older. These percentages changed little from 1997 when they were 59% and 86%, respectively. While current data is unclear, the combination of more baby boomers on Medicare D and the effect of increased eligibility as a result of the Affordable Care Act (ACA) should change these data precipitously.
The nation’s approximately 79 million baby boomers (born 1946-1964) started turning 65 on January 1, 2011. According to the U.S. Census Bureau, the number of Americans age 45 or older totaled 118.4 million in 2010. Americans age 65 and older had the highest voter turnout with 70.3% voting in the national election in 2008. The next age group in terms of voting percentage was ages 45 to 64 where 69.2% of the Americans in this age range voted in the 2008 national election. According to U.S. Census projections, the number of Medicare-eligible seniors will double to 70 million by 2030. Given these demographic facts, unless there is a massive shift in voter registration demographics, the nation’s largest voting bloc will be retirees for many years.

II. Prescription Drug Price Inflation

The Kaiser Family Foundation’s Employer Health Benefits 2007 Annual Survey details how surveyed employers rated the leading factors related to increases in health insurance premium inflation for 2007. The table below summarizes the contributing factors, in rank order, for large firms (200 or more workers) and all firms. The percentage shown reflects the combination of the two responses "A Lot" or "Somewhat" with respect to what factors affect premium increases. Prescription drug costs had the greatest impact on health insurance premium increases and thus retiree living costs. Kaiser has not published data for the years 2008–2012 but other reports suggests that the #1 and #2 rankings are safe.

<table>
<thead>
<tr>
<th>PREMIUM INCREASE FACTORS</th>
<th>RATINGS FROM FIRMS WITH 200 OR MORE WORKERS</th>
<th>RATINGS FROM ALL FIRMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher spending for prescription drugs</td>
<td>1 95%</td>
<td>1 94%</td>
</tr>
<tr>
<td>Higher spending for hospital care</td>
<td>2 94%</td>
<td>2 92%</td>
</tr>
<tr>
<td>Higher spending for medical technology</td>
<td>3 89%</td>
<td>6 85%</td>
</tr>
<tr>
<td>Higher spending for physician services</td>
<td>4 87%</td>
<td>4 88%</td>
</tr>
<tr>
<td>An aging population</td>
<td>5 85%</td>
<td>3 90%</td>
</tr>
<tr>
<td>Insurance Company Profits</td>
<td>6 75%</td>
<td>5 86%</td>
</tr>
<tr>
<td>Workers using more services because they pay a small share of the total Cost of Services</td>
<td>7 68%</td>
<td>7 71%</td>
</tr>
</tbody>
</table>

NRLN’s calculated ten-year expenditures on prescription drugs, 2012–2021, starts with 2011 base year expenditures of $319.9 billion (see I above) and uses the CMS reported spending growth rates (see above) of 2.9% in 2012, 2.4% in 2013, 8.8% in 2014 (ACA) and then an average of 6.6% 2015–2021. Using these data, NRLN calculated prescription expenditures for 2012-2021 to be $4.695 trillion (see Appendix A). Medicare D sales track at 20% of $4.695 and are projected at $978.9 billion over the same period.

During the 2009-2010 health reform debates, the Pharmaceutical Research and Manufacturers of America (PhRMA) promised to reduce prices by a cumulative $80 billion over ten (10) years. The $80 billion would save 1.7% of total prescription drug spending of $4.695 trillion, 8.5% of Medicare spending over ten (10) years. This represents savings of less than 2% of total drug spending. While PhRMA’s gesture is significant, $80 billion in savings is trivial in comparison with the savings that could be generated by the market-based reforms expected from the initiatives supported by the NRLN. PhRMA promised $80 billion to avoid have to accept importation and competitive bidding that would have forced them to compete.
III. Manufacturing and Importing Ingredients and Prescription Drugs

The prescription drug importation debate is in reality two debates: The first involves U.S. importation of drugs that American companies manufacture in the U.S. and sell at significantly discounted prices in other countries. The act of reselling these drugs through U.S. channels is called re-importation.

The second debate concerns the direct importation of drugs manufactured in other countries and exported to the U.S. Most American companies manufacture offshore and are therefore de facto importers. Not surprisingly, American drug manufacturers oppose re-importation and importation of competitor’s prescription drugs.

The NRLN’s view is that the discussion or debate regarding importation should center on importation as the common term used to describe importation of prescription drugs from all sources into the U.S. The issues that we need to deal with arise only when products or services enter and are consumed in our country.

The fact is that most pharmaceutical ingredients used by American pharmaceutical companies are manufactured overseas. A January 20, 2009 New York Times article by Gardner Harris reveals that "the critical ingredients for most antibiotics are now made almost exclusively in China and India." The same is true for other crucial medicines used for such things as diabetes and high blood pressure. The NYT article reports that of the 1,154 pharmaceutical plants mentioned in generic drug applications to the FDA in 2007, only 13% were in the United States, while 43% were in China and 39% were in India. Overall, one federal database lists 3,000 overseas drug plants while another lists 6,800 plants. There is no evidence that this situation has shifted direction over the 2008 - 2012 timeframe.

"Drug labels often claim that the pills are manufactured in the United States, but the listed plants are often the sites where foreign-made drug powders are pounded into pills and packaged," according to the New York Times January 20, 2009 article by Gardner Harris.

Ingredients and pills processed offshore are sold into foreign countries at much lower prices than in the U.S. This places the American consumer in the position of having to pay excessive prices that effectively subsidize the lower offshore prices and increase U.S. prescription drug manufacturer profits at the expense of American consumers. R&D costs are recovered in the early years of patent protection.

The American public, particularly retirees and all seniors, pay artificially inflated high prices for pharmaceutical products. The NRLN asserts that retirees deserve a stabilized marketplace where open competition among global manufacturers naturally lowers the price of safe pharmaceutical drugs.

The Kaiser Family Foundation 2009 chart below shows that Pharma companies reap 3 to 4 times the profit earned by all Fortune 500 companies including Pharma companies.
Pharmaceutical manufacturers and their lobbyists have convinced some on Capitol Hill that a 2003-04 assertion that importation will lead to “parallel trade” and ruin the competitive market place and therefore is a threat to the U.S. market is valid. The logical answer they say is to preclude importation.

A paper produce by EurActive, www.euractiv.com in 2003 and updated on August 3, 2007 defines parallel trade: ‘Parallel trade’ in the pharmaceutical industry occurs where drug prices vary from country to country due to national price regulation. A wholesaler in low price country A will be able to get a better price by selling in high price country B rather that in domestic market A. Price differences can be due to either, national regulations, exchange variations or prices setting strategies by pharmaceutical companies. Parallel importing is legal in the European Union.

Medicare could buy direct from manufactures only and contract with one or more U.S. distributors who could be prohibited from shipping goods received from any other designated source to Medicare participants. Foreign manufacturer contracts would prohibit them from substituting under penalty of immediate non-recourse termination of a contract. In short, if Medicare or any other retail prescription drug chain or single company wanted to engage in offshore direct ship agreements with manufacturers, they can, in any industry. All U.S. businesses that do business anywhere in the world must manage currency differences and trade differentials. There are no conditions that cannot be well managed and done so easily.

The NRLN estimates that a well-managed importation plan for prescription drug ingredients and finished products would save U.S. consumers 5% of the $4.7 trillion in total U.S. drug expenditures over the 2012-2021 ten-year period, a savings of $235 billion. Medicare savings would be 5% of nearly $978.97 billion or $48.9 billion over the same period.
Readily achievable quality standards and controls and an adequately staffed and funded FDA can make prescription drug pricing more competitive and would lower drug prices for Americans retirees and all U.S. citizens. Paying $100 for a prescription drug in the U.S. but $10 for the same drug in Canada or $5 in Germany or France is shameful, and effectively increases the cost of prescription drugs for every American.

IV. Competitive Bidding of Prescription Drugs

The Centers for Medicare and Medicaid Services (CMS) should be allowed to construct a robust Medicare Part D formulary and issue Request for Quotes (RFQ’s) for prescription drugs paid for via the Medicare Prescription Drug Program. This practice has served the Veterans Administration well.

Some opponents of competitive bidding say the Veterans Administration (VA) formulary is not broad enough to serve everyone’s needs and that a more complex formulary would not be workable, but this is really not an issue at all. Only those not familiar with commercial bidding and contracting process are fooled by red herring rhetoric passed on by industry lobbyists. There are no unsolvable purchasing and or distribution problems in today’s commercial world.

The Kaiser Family Foundation 2009 chart (see pg 6) shows that Pharma companies reap 3 to 4 times the profit earned by all Fortune 500 companies. Competitive bidding for Medicare business by global manufacturers will lower prescription drug costs, the federal budget and deficit and is long overdue. The NRLN does not oppose honest profits, but not those at the expense of our country’s seniors.

As brand name drugs lose patent protection, the market place will shift more to a generic-based market. Brand Name manufacturers are also major generic manufactures and they are also buying generic manufacturing companies to bolster their market positions moving forward. As in all consumer product businesses, account control and consumer mindshare are critical. No brand company wants to lose either account control or consumer mindshare.

The May 2010 Kaiser Family Foundation report on Prescription Drug Trends reported that in 2008 22% of total prescription drug dollar sales, and 72% of total number of prescriptions dispensed, were for generic medicines. Only 28% of all prescriptions were filled with brand label drugs, yet 78% of all sales went to brand label manufacturers. In 2011, 75% of all prescriptions filled were filled by generic drugs. Brand label manufacturers will fight to retain sales and profits. If competitive bidding of Medicare prescription drugs is not in place soon, we will see bidding up of generic prices by the same manufacturers who enjoy higher pricing and profit margins today (Kaiser Chart on page 6).

Some assert that authorizing Medicare to manage a bidding process and the distribution of prescription drugs would be a daunting task. Others object to Medicare’s setting drug formularies; they assert that Medicare is not qualified for the job. These objections are baseless; there are proven processes and skilled people available that are equal to the challenge. Some claim that the process could not apply to both patented and generic products. The NRLN asserts that when more than one patented drug or more than one generic drug can cure the same illness, bidding is appropriate. The NRLN does not support patent infringement.

The big picture issue is that in the absence of Medicare awarding bid contracts where generics drug makers bid against each other for 75% of Medicare’s prescription drug purchases of $115 billion, by 2021, the generic market could be controlled by brand manufacturers who are a rapidly growing segment of the generic business and whose profit margins are 3 to 4 times the average of all Fortune 500 companies. Competitive bidding for Medicare’s business would stimulate price competition.
The NRLN estimates that competitive bidding would reduce prescription drug costs for combined Medicare and non-Medicare payments over the 2012-2021 period and save U.S consumers a minimum of 5% of $4.7 trillion, or $235 billion over the 2012-2021 period. Medicare savings would be 5% of $978.9 billion or $48.9 billion over the same period.

V. The Case for Breaking the Generic Drug Log Jam

In AARP’s May of 2006 Bulletin, Barbara Basler reported that generic drugs accounted for 56% of all prescriptions filled and that there was an FDA backlog of 800 generic drugs to be approved. She reported that the time the FDA took to approve new brand drugs was less than nine (9) months but that it was taking seventeen (17) months to approve a generic drug.

Generics comprise the vast majority of prescriptions consumed, yet the FDA gives them a low priority. The May 2010 Kaiser Family Foundation report on Prescription Drug Trends reported that in 2008 22% of total prescription drug dollar sales, and 72% of total number of prescriptions dispensed, were for generic medicines. IMS Healthcare similarly reported in April 2011, that generic sales accounted for 78% of all retail prescriptions dispensed in 2010. The IMS report did not state the 2010 estimated sales value of these dispense generic prescriptions.

In April 2006, an FDA study revealed that there were just 200 members of the FDA staff assigned to test and approve 975 submitted generic drug applications annually or one staff member for every 4.88 applications. At a rate of 4.88 per staff member, the seventeen (17) month approval interval suggests that it would take 5.5 years just to clear the generic backlog. By comparison, Brand Name drug applications receive VIP treatment. The study reported that the FDA assigns 700 staff members to test and approve 150 Brand Name drug applications annually, or one staff member for every 0.21 applications, on average. The study reveals that brand manufacturers pay user fees to make sure the FDA is adequately staffed to approve brand drugs. The FDA’s long-standing practice has been to not even offer generic drug makers the option, let alone require them, to pay user fees to fund expedited generic drug approvals. Fortunately, Congress recently passed an amendment allowing manufactures of generic drugs to pay FDA user fees that previously could only be paid by brand manufacturers. While such fees may cover a significant portion of U.S. generic manufacturer approval costs, the FDA must staff to anticipate an ongoing growth of generic applications and to support safety and approval of globally manufactured imported products and insure that backlogs are reduced below six (6) months on an ongoing basis.

The study noted: When two generic drugs compete with a Brand Name drug, market prices drop 50%. When three generic drugs compete with a brand drug, market prices drop 75%. The FDA study didn’t state savings for one-on-one competition, but it’s safe to assume its 25% or more.

Gary Bueller, the Director of FDA’s Generic Drugs division, told Forbes (August 29, 2008) that the interval to review a generic drug had lengthened from 17 to 19 months and that generic applications for 2008 were expected to be 1,500, a 54% increase over 2006. Some but not enough has changed to improve FDA efficiency or to reduce barriers to market entry of generic drugs since 2008.

FDA paperwork and rules cause delays in the approval process and need to be revised or eliminated to achieve better efficiency and to afford more equitable treatment to generic manufacturers. Brand name drug manufactures pay certain fees to the FDA that supplement the approval process budget for brand drugs.
Rules are complicated and require that generic manufactures pay legal and other consulting fees in order to understand and comply with the meaning and intent of FDA rules.

The NRLN estimates that adequate FDA funding and staffing will greatly increase the capability to accelerate generic drug approvals, improved efficiencies and rule changes that will create an even better playing field for generic drug manufacturers and would save U.S. consumers 3% of $4.7 trillion or $141 billion over the 2012-2021 period. Medicare savings would be 3% of $978.9 billion or $29.4 billion over the same period.

VI. Brand and Generic Drug Manufacturing Restraint of Trade

The Washington Post, in a February 3, 2009 article written by Lyndsey Layton, reported that the Federal Trade Commission ("FTC") has found that nearly half of the patent settlements between generic drug makers and Brand Name manufacturers in fiscal 2006 and 2007 resulted in some kind of payment to the generic maker in exchange for a pledge to stay out of the marketplace. These payments – sometimes called "pay-for-delay," "reverse payments “or” exclusion payment settlements" – keep generic drugs off the market that could be 75% less costly for consumers. FTC officials say these deals violate anti-trusts laws, deny consumers of less-expensive drugs, and allow brand drug makers a monopoly. "We want to stop these unconscionable pay-for-delay deals that force consumers to overpay for much-needed drugs" said Jon Leibowitz, an FTC commissioner and the FTC’s current chairman.

While it is common for two companies to enter into a business agreement, these arrangements should not result in pricing arrangements, carving up markets or combining in a way that squeezes out smaller non-selected industry competitors. Selected generic company recipients of brand manufacturer financial support and counseling on how to weave through the FDA approval and market entry process, may gain an advantage over other generic manufacturers. The NRLN feels the net effect of pay-for-delay and other practices operate to the disadvantage of retirees and all consumers in the long run.

A major breakthrough occurred in 2012 when the Philadelphia 3rd Circuit court ruled that pay-for-delay was a restraint of trade practice and ordered that the practice be stopped. The defendants in the case have appealed to the Supreme Court. The NRLN urges Congress not to wait for the Supreme Court to act, but should instead move quickly to amend the law to prohibit pay-for-delay now.

The NRLN believes that preventing anti-competitive practices (pay-for-delay) will save U.S. consumers 1% of $4.7 trillion or $47 billion in the prescription drug spending over the 2012-2021 time period. Medicare savings would be 1% of $978.9 billion or $9.8 billion over the same period.

VII. Summary of Proposal Savings:

If Congress takes steps to enact legislation to implement NRLN’s proposals they could save U.S consumers $657.5 billion or 14% of total projected prescription drug expenditures of $4.7 trillion over the 2012-2021 time period.

Medicare savings would be 14% of $978.9 billion or $137.1 billion over the 2012-2021 time period; an annual average savings of $13.71 billion.
Appendix A: Table of Projected Prescription Drug Expenditures and Savings – 1/10/13

January 10, 2013 Update

<table>
<thead>
<tr>
<th>Year</th>
<th>CMS Estimated Growth *</th>
<th>Annual Spending U.S Market **</th>
<th>Medicare Prescription Drugs ***</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>2.9%</td>
<td>$329.2</td>
<td>$68.6</td>
</tr>
<tr>
<td>2013</td>
<td>2.4%</td>
<td>$337.1</td>
<td>$70.3</td>
</tr>
<tr>
<td>2014</td>
<td>8.8%</td>
<td>$366.7</td>
<td>$76.5</td>
</tr>
<tr>
<td>2015</td>
<td>6.6%</td>
<td>$390.1</td>
<td>$81.5</td>
</tr>
<tr>
<td>2016</td>
<td>6.6%</td>
<td>$416.7</td>
<td>$86.9</td>
</tr>
<tr>
<td>2017</td>
<td>6.6%</td>
<td>$444.3</td>
<td>$92.6</td>
</tr>
<tr>
<td>2018</td>
<td>6.6%</td>
<td>$473.6</td>
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<tr>
<td>2019</td>
<td>6.6%</td>
<td>$504.8</td>
<td>$105.3</td>
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<tr>
<td>2020</td>
<td>6.6%</td>
<td>$538.1</td>
<td>$112.2</td>
</tr>
<tr>
<td>2021</td>
<td>6.6%</td>
<td>$573.7</td>
<td>$119.6</td>
</tr>
</tbody>
</table>

10 Years Drug Spending (rounded)  
10 Year Savings Totals (rounded)  
10 Year Savings is of Total Spending

<table>
<thead>
<tr>
<th>Proposal</th>
<th>% Savings</th>
<th>Ten Year Savings 2012 - 2021</th>
<th>Ten Year Savings 2012 - 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Importation of FDA Approved Drugs</td>
<td>5%</td>
<td>$234.8</td>
<td>$48.9</td>
</tr>
<tr>
<td>Competitive Bidding and Formularies</td>
<td>5%</td>
<td>$234.8</td>
<td>$48.9</td>
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<tr>
<td>Expanded FDA Funding &amp; Staffing</td>
<td>3%</td>
<td>$140.9</td>
<td>$29.4</td>
</tr>
<tr>
<td>Elimination of Pay-for-Delay</td>
<td>1%</td>
<td>$47.0</td>
<td>$9.8</td>
</tr>
</tbody>
</table>

| 10 Year Savings Totals (rounded)              | 14%       | $657.5                        | $137.0                      |

| % 10 Year Savings is of Total Spending        | 14.0%     | 2.9%                          |

* CMS National Health Expenditure Projection 2011-2021  
** IMS HEALTH report February 21, 2012  
*** The 2012 Annual Report of the Board of Trustees
Appendix B: Prescription Drug Cost Impact on Health and Disposable Income

A sampling of reports from individual retirees around the country:

From: Delbert Polad, St. George, UT
CenturyLink (Qwest) Retiree
I am a member of AUSWR – the Association of U S WEST Retirees. For the last seven years I have had CML leukemia. There is no cure, but a there is a standoff by taking a $150 per day pill called Glevac, This amounts to $4,500.00 per month. If I were to lose my health care benefits, I could not afford to pay for this daily treatment. To compound matters, my investments that my wife and I have lived off of have not done well, so we will soon be living off only Social Security. If we take any reductions on Social Security or Medicare, we don't know what we will do.

###

From: Mary Sheipline, West Bloomfield, MI
General Motors Retiree
Because I MUST take brand name drugs (tier 2 and 3), I am paying more out of pocket. I hit the donut hole in June. My cancer medication didn't have a generic so it was $500 out of pocket every 3 months.

###

From: Ronald Herron, Lake Orion, MI
General Motors Retiree, Age 63
Since my retirement, my employer-sponsored prescription, dental and vision coverage has been eliminated. I have already had to forego buying a prescribed medicine because the cost would devastate my monthly retirement budget. The high prices for prescription drugs have already changed the life my wife and I had expected to live in retirement.

###

From: Richard Clark, Rochester Hills, MI
MichCon (DTE Energy) Retiree, Age 90
I am 90 and my wife is 89. We currently have secondary health coverage and prescription drugs from my former employer. If I were to lose this coverage, we will have to discontinue our medication which would surely result in death in a short time. Without prescription drug coverage our meds would cost $1,500 a month and who knows what health care would cost if available to us.

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From: Charlie Gray, Springwater, NY
Eastman Kodak Retiree
My wife and I both have life threatening conditions. While we are not poor, we just discovered that the "doughnut hole" in Medicare Part D will affect us both in terms of what we can afford. Fortunately, we live within 100 miles from Canada. We are getting our passports and will travel once a month to Canada to purchase our medicines. Shouldn't be this way, and we're pissed!

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From Paula R. Brock, West Chester, OH
Chrysler Retiree
   PLEASE...PLEASE...PLEASE do not let the government reduce Social Security and Medicare. I could not make it if this was to occur. Money is tight as it is now for us retired "oldies." By the time we buy our medicine, food, pay bills, etc., there just isn't anything much left.

From Claude Isnard, Pearland, TX
Alcatel-Lucent Retiree
   Occasionally, I receive a prescription from a doctor at the VA because the RX he prescribes is not available through the VA line. Example: one month ago, I received an Rx for allergy/decongestant. That specific Rx was (is) not available through the VA channels since it is not a "generic". At Walgreen, a three-month supply would have cost me $220.00. At Walmart, the price was $200.00. Too expensive for me! Then, I went "on-line" and connected with a pharmacy in Canada. A SIX-MONTH SUPPLY would cost me $110.00. Yet, we are not officially allowed to receive drugs from Canada!

From Jim Marot, Parker, CO
Alcatel-Lucent Retiree
   I have recently experienced a situation, when I ordered a refill of one medication, the pharmacist told me that the cost for a 30 day supply was $800.00 plus! They stated that they had talked to the Insurance Company and the Brand name drug company. They said they could not do anything about it. Wow! We contacted our doctor and he researched various alternates and options and found a medication that cost me $10.00. This is an example of the awful disregard for the public individual.