House Energy and Commerce Committee, Subcommittee on Health

Prescription Drug Coverage in the Medicare Program

April 30, 2019

10:30 AM, 2322 Rayburn

Purpose

The purpose of this hearing was to hear from Mr. James Mathews, Executive Director of the Medicare Payment Advisory Commission (MedPAC), regarding drug pricing in the Medicare program.

Members Present

Chairman Eshoo, Representatives Bucshon, Pallone, Walden, Matsui, Shimkus, Schrader, Guthrie, Ruiz, Bilirakis, Kuster, Carter, Blunt Rochester, Barragan, Gianforte, Kelly, Welch, Soto, and Sarbanes

Witnesses

Mr. James Mathews, Executive Director, Medicare Payment Advisory Commission

Opening Statements

Chairman Eshoo said that the committee is committed to lowering drug prices for seniors and families across the country. Today, the committee is going to take a close look at the Medicare program to determine what is leading to high drug costs for millions of seniors. Congress must act and wants to act. Medicare accounts for one out of every three dollars spent on prescription drugs. Costs are rising in both Part B and Part D. These rising costs are putting unsustainable pressure on the Medicare program and on American families. America leads the world in innovative health care, but soon, no one will be able to afford this care. Because Medicare has no limit on out-of-pocket spending, seniors who rely on specialty drugs are particularly hard hit.

Rep. Bucshon said that this hearing is an important opportunity to receive expert advice from MedPAC as Congress addresses the issue of drug costs. Medicare enrollees are generally satisfied with their coverage, and the Part D program has saved taxpayers billions of dollars. However, too many seniors still struggle to afford their medications. The Trump Administration has proposed changes to both Parts B and D to help lower costs. These proposals should be carefully analyzed to understand their full impact. Any approach that Congress takes should not punish patients, physicians, or stifle innovation.

Rep. Pallone said that this committee has already passed several bills that will encourage more generic drugs to come to market, and today the committee is examining the cost of drugs in the Medicare program. Congress can't wait any longer to fix this broken system. The incentives in the current system can be gamed for profit at the expense of vulnerable patients. This is of particular concern in the Part D program, with high cost specialty drugs making up more than a quarter of drug spending. Each year, more and more beneficiaries are reaching the catastrophic phase of the Part D program. Part B spending has also increased at a rate of nearly 10 percent per year for the past decade. Though more and

more innovative therapies are being developed, they also come with price tags that make them inaccessible to many Americans.

Rep. Walden said that MedPAC provides a valuable service to lawmakers, and their input is important as Congress seeks to address rising drug costs in the Medicare program. Medicare Part D has been a hugely valuable program. However, there are problems with the program that saddle patients with unsustainable out-of-pocket costs and costs the government too much money. Congress must work to realign incentives in the program to better help patients. There are also rising costs in the Part B program, and there are areas where Part B reimbursement can be improved.

Testimony

Mr. Mathews said that Part B covers drugs that are typically administered by a provider. Medicare reimburses the average sales price (ASP) plus six percent. Growth in Medicare spending on Part B is driven largely by rising drug costs, which reflects the drug makers' significant pricing leverage. Medicare has few tools to effect prices under Part B. Part D uses private plans to deliver Medicare's outpatient prescription drug benefit. Part D plans negotiate with pharmacies and drug manufactures, and Medicare is prohibited from interfering in these negotiations. Part D spending has grown at about seven percent annually between 2010 and 2017, but Medicare's reinsurance payments for Part D enrollees who reach the catastrophic phase of coverage grew by about 20 percent annually over that same period. This is driven largely by high-cost therapies. The growth in Medicare spending overall reflects the rising prices of existing products, and the introduction of new high-cost products. Several proposals could improve Medicare's ability to effect prices. In Part B, Medicare could provide clinicians with an alternative to the "buy and bill" environment, and incentivize them to use that approach. In Part D, Medicare could shift more liability for costs in the catastrophic phase to plans, and in exchange, give plans more tools and flexibility to manage utilization. Medicare could also eliminate beneficiary cost-sharing in the catastrophic phase.

Questions and Answers

Chairman Eshoo asked what plans can do to better manage the cost of new specialty drugs, and how other federal programs like the Veterans Administration (VA) address this issue. **Mr. Mathews** said that plans have an incentive to place high cost drugs on their formularies, even when lower cost options are available, because if a beneficiary moves into the catastrophic phase of the benefit, the plan only has liability for 15 percent of those costs. MedPAC has considered a proposal that would shift some liability to drug manufactures to better align incentives. Part of VA's ability to address prices is comes from having a closed formulary.

Rep. Bucshon said that the administration has proposed a policy where providers would use third-party vendors to obtain drugs in Part B, similar to a MedPAC recommendation. He asked why MedPAC recommended that this change be voluntary, and how it would foster competition. **Mr. Mathews** said that MedPAC recommended the use of vendors to counter the inflationary aspects of Part B. The higher the cost of the drug, the higher the six percent add-on of the reimbursement. So removing the clinician from that process could reduce the perverse incentives. **Rep. Bucshon** asked if MedPAC considered the potential negative consequences of

step therapy and other such requirements when recommending that plans take on more liability. **Mr. Mathews** said yes. As always, there are tradeoffs involved in these decisions.

Rep. Pallone asked why there has been such steep spending increases in Part D. **Mr. Mathews** said that Part D has been successful in promoting generic drugs, but at the same time, there have been many new high-cost specialty therapies that have been introduced, and those are driving cost. **Rep. Pallone** asked how Part D could be changed to address this issue. **Mr. Mathews** said that Part D could be restructured to give plans more of an incentive to manage utilization above the catastrophic limit. **Rep. Pallone** asked how difficult it is to control the cost of single-source therapies. **Mr. Mathews** said it is hard to control costs with no competition. Plans will have fairly limited leverage, which is why MedPAC is considering proposals to give manufactures some liability for costs in the catastrophic phase. **Rep. Pallone** asked which Part B drugs are the most expensive. **Mr. Mathews** said the most expense are specialty drugs, predominantly biologics used to treat cancer and other chronic illnesses.

Rep. Walden asked how financial incentives have affected Part D formularies. **Mr. Mathews** said that in certain instances, plans have included high-cost, high-rebate drugs on their formularies, even when lower cost alternatives are available. **Rep. Walden** asked how this affects Part D spending. **Mr. Mathews** said that the fastest growing area of Part D spending is reinsurance payments to plans for beneficiaries in the coverage gap.

Rep. Matsui said that the administration has proposed changes to the protected class policy that would allow Part D plans to limit medications available to seniors. The protected class policy is an important safety net for patients who absolutely need potentially live saving medications. She asked how Medicare can ensure continued availability of needed medications while making changes to the protected classes. **Mr. Mathews** said that MedPAC has recommended removing two categories of drugs from the protected classes, antidepressants and immunosuppressants. The rational was that there are enough alternatives available in those categories that plans could put together sufficient formularies. The administration's proposal is slightly different in that it would give plans more flexibility to use utilization management within those classes. **Rep. Matsui** asked how capping out-of-pocket spending for Part D beneficiaries would impact premiums. **Mr. Mathews** said that capping cost-sharing above the catastrophic phase would reduce the punitive nature of those beneficiaries' cost.

Rep. Shimkus asked what programs existed to help beneficiaries get prescription drugs prior to Part D. **Mr. Mathews** said there were none. **Rep. Shimkus** said it is important for Congress to fix the issue of the donut hole, because too many beneficiaries are getting trapped with enormous costs.

Rep. Schrader asked if MedPAC has evaluated whether Medicare would benefit from value-based reimbursement. **Mr. Mathews** said that MedPAC is aware of the emergence of such value-based arrangements. However, they are new enough that there is not yet a broad base of evidence on their effectiveness. One potential impediment to Medicare implementing value-based arrangements is the voluntary nature of Part D. Beneficiaries can change plans year to year, so a plan might not see the benefit of their investment in a beneficiary. **Rep. Schrader** asked if MedPAC has considered increasing the cost of brand name drugs in an effort to make

generics more appealing. **Mr. Mathews** said that beneficiaries should be given incentives to use generics when they are available, such as a zero dollar co-pay for a generic, or moderate financial liability if they choose a brand name drug.

Rep. Guthrie asked if Mr. Mathews supports transparency tools like a real-time benefit check. **Mr. Mathews** said yes. **Rep. Guthrie** asked how Congress can encourage the use of these tools. **Mr. Mathews** said that he would need to think about that. **Rep. Guthrie** asked if site-neutral payment reform could help address both rising costs to Medicare and costs to patients. **Mr. Mathews** said yes. MedPAC has been concerned about the perverse incentives that exist because of the difference in hospital versus physician office payments.

Rep. Ruiz asked what safeguards the Centers for Medicare and Medicaid Services could put in place to protect patients from unnecessary and potentially harmful step therapy treatments. **Mr. Mathews** said that MedPAC supports giving plans the flexibility to appropriately use care management tools. A robust and efficient appeals process must accompany the greater use of these tools.

Rep. Bilirakis asked if MedPAC supports the administration's international pricing proposal. **Mr. Mathews** said MedPAC identified several logistical issues with that proposal that would make it difficult to implement. **Rep. Bilirakis** asked if there are examples of binding arbitration being used in health care that include setting prices at the federal level. **Mr. Mathews** said that binding arbitration would give Medicare the ability to influence price. Currently, the Medicare program has virtually no means to influence price.

Rep. Kuster asked what the original intent was behind the ASP plus six percent payment model. **Mr. Mathews** said that there are a number of competing explanations for the six percent add-on. The most compelling explanation is that smaller providers often pay above the average price for drugs, and therefore the six percent add-on makes up for that. **Rep. Kuster** asked if MedPAC has examined the impact of allowing the Health and Human Services Secretary to negotiate a volume discount on prescription drugs. **Mr. Mathews** said that MedPAC has not taken a position on this issue.

Rep. Carter asked how DIR fees affect beneficiaries. **Mr. Mathews** said that beneficiaries at the point of sale are paying more in cost-sharing than they should be. **Rep. Carter** asked how Medicare plans cover the cost of insulin, especially for beneficiaries in the donut hole. **Mr. Mathews** said that MedPAC's plans to restructure the benefit would reduce the incentives for plans to use high-cost, high-rebate drugs.

Rep. Blunt Rochester asked why low-income beneficiaries tend to use more brand name drugs. **Mr. Mathews** said MedPAC believes that low-income beneficiaries, whose costs are heavily subsidized, are not as sensitive to the higher price of brand name drugs. **Rep. Blunt Rochester** asked how MedPAC developed its recommendations for increasing generic use among low-income beneficiaries. **Mr. Mathews** said he would like to follow up in writing.

Rep. Barragan asked if MedPAC has studied how much money the government would save if Medicare had the ability to negotiate drug prices. **Mr. Mathews** said no, MedPAC has not done

an independent analysis of price negotiation. **Rep. Barragan** asked if MedPAC will conduct such a study. **Mr. Mathews** said MedPAC would be able to evaluate some of the logistical issues in a qualitative way. **Rep. Barragan** asked if MedPAC has evaluated racial disparities in the Part D program. **Mr. Mathews** said not to his knowledge. **Rep. Barragan** asked if they could. **Mr. Mathews** said he would be happy to talk to his staff about what they can do with the resources available to them.

Rep. Gianforte asked how hospital consolidation has affected the cost of prescription drugs and seniors' out-of-pocket expenses. **Mr. Mathews** said provider consolidation has the potential to increase Medicare spending. **Rep. Gianforte** asked how pricing disparities for the same service provided at a hospital versus physician practice impact the cost of Part B drugs. **Mr. Mathews** said it has the potential to impact beneficiaries' out-of-pocket costs. **Rep. Gianforte** asked if MedPAC has made any recommendations to address this differential. **Mr. Mathews** said yes. MedPAC has identified a set of services that are most often provided in a doctor's office and are appropriate candidates for a Medicare site-neutral payment policy. **Rep. Gianforte** asked if a site-neutral payment policy would reduce senior's out-of-pocket costs. **Mr. Mathews** said he could not say off the top of his head.

Rep. Kelly asked how many of the most expensive drugs in Part B face competition from a biosimilar. **Mr. Mathews** said he believes two of the top ten have biosimilars on the market, but they have not had a significant impact on the price Medicare pays for the original biologic. MedPAC has recommended combining the billing codes of biologics and biosimilars so that Medicare pays for the average of those two products.

Rep. Welch asked if Mr. Mathews would support legislation that includes price negotiation as a tool for Medicare. **Mr. Mathews** said MedPAC has not weighed in on the issue of direct negation. Their standing recommendation is to allow for binding arbitration.

Rep. Soto asked if there should be a carve out for cancer and other fatal diseases if a plan implements a step therapy requirement. **Mr. Mathews** said that MedPAC has not contemplated a carve out based on medical conditions, but they have recognized the need for a robust exception and appeals process. **Rep. Soto** asked what role Congress should play in preventing the price of existing drugs from skyrocketing. **Mr. Mathews** said that rising costs are partly the result of truly revolutionary products being introduced. But there have also been many instances of products that have been on the market for decades becoming more and more expensive. MedPAC has recommended an inflation rebate that would check the ability of manufactures to increase their prices year over year beyond the inflation rate.

Rep. Sarbanes asked what Mr. Mathews thinks of setting upper limits on the price of lifesaving drugs. **Mr. Mathews** said that MedPAC has not taken a position on setting a price cap. MedPAC has proposed the inflation rebate which is guided by the notion that drugs that have been on the market for a long time are essentially commodities, and their prices should go down over time.

Rep. Eshoo said that people have died due to step therapy requirements. MedPAC needs to develop better recommendations in this area.

Rep. Bucshon agreed that step therapy is an ill-advised policy. He asked if the Congressional Budget Office (CBO) has ever studied the effect of out-of-pocket cost caps. **Mr. Mathews** said that MedPAC has recommended such a cap. He would be interested to see a CBO analysis.