SUMMARY

The Subcommittee on Health of the Committee on Energy and Commerce held a hearing on April 30, 2019 on prescription drug coverage under Medicare.

Find the testimony of **Dr. James E. Mathews**, the Executive Director of the Medicare Payment Advisory Commission (MEDPAC) here.

Find the full livestream video of the hearing here.

I. Opening Remarks

Chairwoman Eshoo (D-CA): The purpose of this subcommittee hearing is to look at see what is leading to such high prescription drug costs with the Medicare program.

Rep. Bucshon (R-IN): MEDPAC is an important resource for Congress as legislation moves forward on prescription drug pricing and what is best for beneficiaries. Parts B & D of Medicare are vital to providing seniors with affordable drugs, and it is necessary to better understand these programs. The administration's proposed changes should be carefully analyzed, and with bipartisanship, work on lowering drug costs in the process.

Rep. Pallone (D-NJ): The subcommittee has already passed multiple bills to help lower prescription drug costs, and the hearing today is to do the same in the Medicare program for seniors. The system is currently broken.

Rep. Greg Walden (R-OR): It is time to modernize Medicare Parts B & D, and maintain affordability of drugs for seniors.

II. Dr. Mathews' Testimony

III. Questioning by the Subcommittee Members

Chairwoman Eshoo: How are the programs handling this high drug-cost trend?

Rep. Bucshon: Why did MEDPAC propose a voluntary program, a vendor-based approached, as opposed to the Administration's proposal of making it mandatory for physicians? Are there savings with the addition of another "middle person" in these negotiations, why need this additional vendor? In MEDPAC's recommendations for Part D, shifting payments to allow more flexibility with formulary tools (as a physician, Rep. Bucshon had difficulties with these formularies in the past), why were these recommended?

> **Dr. Mathews:** MEDPAC was concerned for inflationary incentives. The research is limited if providers are acting on those incentives, but the incentives are still there. The savings also reach the physicians who voluntary join, for the

incentives. As for formulary tools, there is always a tradeoff – MEDPAC understands the frustration, yet wanted to achieve balance in the program.

Rep. Pallone: MEDPAC analyzed an increase in Part D spending that is unsustainable, where are these increases coming from? What are some of MEDPAC's solutions to control spending in Part D? Without competition, how difficult is it to control costs? Could you provide examples of the most expensive drugs in the Part B program?

Dr. Mathews: The entry of high cost specialty drugs into the program, driving the increase of spending. One of the key elements is a restructure of the plans, making them more incentive based. It is increasingly difficult to control costs without competition, and with responsibility for 80% of those costs, restructuring is key. MEDPAC is starting to contemplate the manufacturer's liability as a result. In Part B, predominately biologics to treat cancer, side effects of arthritis etc. are the high costs.

Rep. Greg Walden: There are disturbing trends of rising out of pocket costs, and the incentives to use brands over generics are problematic. Can you explain some of these issues?

Dr. Mathews: The reinsurance payments are the highest costs in the programs, and the Medicare program directly funds these payments, which has proven detrimental to tax payers.

Rep. Matsui (D-CA): There is a need to protect beneficiaries' access to these prescription drugs – the protected classes policies is a vital safety net. Changing this policy will jeopardize access to drugs to treat mental illness, for example. Rep. Matsui hopes that MEDPAC's recommendations are sensitive to this issue for beneficiaries. As for out of pocket spending in Part D, there is no current limit – can you explain MEDPAC's recommendation to cap this spending beyond the catastrophic phase?

Dr. Mathews: MEDPAC did recommend removing two drugs from these protected classes, the rationale being that there were enough alternatives available to do so, without having to cover every drug under this policy. The balance is beneficiary access, and if the plan has to cover every single protected class drug, there is virtually no leverage for lowering cost. There is a strong need for a well-functioning appeals process as well. The recommendation to cap out of pocket spending was just as necessary for beneficiary protections.

Rep. Shimkus (R-IL): Highlighted the importance of veteran access to prescription drugs as well. What benefit was provided to seniors prior to Medicare Part D? Rep. Shimkus was surprised at how much liability is still on the beneficiaries.

Dr. Mathews: There was no real benefit before Part D. MEDPAC is in full agreement liability currently remains on beneficiaries, hence MEDPAC proposals to address this problem.

Rep. Schrader (D-OR): Oregon's 1115 waiver to get a value-based payment by 2020, as are other states. Has MEDPAC evaluated whether Medicare can benefit from value-based payments? What remedy does MEDPAC recommend to increase the use of generics?

Dr. Mathews: The evidence on the long-term effectiveness on these programs does not yet exist, as it is too new. With respect to Medicare, one impediment to this is the voluntary nature of Part D – plans may not see the benefits of these value-based payments as beneficiaries have the voluntary choice to change plans, hence a logistical issue to start. MEDPAC does recommend the incentives for generics overall, either in zero co-payments or some nominal financial liability of using brand name drugs when generics are available. Either achieves the goal of low-income beneficiaries using more generics, according to MEDPAC.

Rep. Guthrie (R-KY): Rep. Schrader asked, almost word for word, the questions Rep. Guthrie had for Dr. Mathews. What policies should be developed for the use to electronic health data tools? Will MEDPAC address beneficiaries getting treatments in hospitals that can be done in a physician's office?

Dr. Mathews: Need to be thought about – technology does exist for current electronic health records. The problem is the purchase of proper models, and incentive for physicians to use these models, to maintain this technology for records. More can be done, as MEDPAC is concerned with the clinician services in a physician's office versus a hospital, with a need to eliminate the lack of sustainability in doing so.

Rep. Ruiz (D-CA): Last Nov., CMS recommended a step-therapy proposal to lower drug costs – Rep. Ruiz believes this recommendation does not consider the health background of all beneficiaries. The SAFE Step Act allows patients to not be forced into this step-therapy if it is proven to not work for them – what are safeguards that CMS can use as a result?

Dr. Mathews: MEDPAC would not support a proposal that would force the beneficiaries to endure a failed method (i.e. step therapy) as treatment. There is no clinical basis to answer what "failure" means in a method of providing health on behalf of MEDPAC. MEDPAC can follow up on this after the hearing. The commission is aware that Part D appeals are being monitored, and a majority are adjudicated in favor of the patients, and CMS is monitoring beneficiary access at this time.

Rep. Bilirakis (R-FL): Is it correct that MEDPAC's drug pricing proposal is more market-based than the administration's? Is there an awareness of arbitration?

> **Dr. Mathews:** MEDPAC identified logistical issue to the administration's proposal, making it difficult to implement, such as no tools/formularies/mechanisms of negotiations available to vendors. The vendor would be paid at a rate determined by Medicare, whether or not they were able to obtain that rate in the market or not. One of the vulnerabilities of the Medicare program is that it has little to no ability to affect the price that a manufacturer sets for a product – binding arbitration would give the program a means for influencing that price.

Rep. Kuster (D-NH): On the buy-in bill program, under the current Part D program, reimbursement is at 106% reimbursement regardless of the price actually paid. Can you explain the original intent on this? Has MEDPAC ever examined the impact of this by authorizing a volume discount by CMS?

> **Dr. Mathews:** There are competing alternative opinions, and the explanation is unclear. The 6% can be explained by storage and handling of the drug, for example. There are components that cover normal overhead. The most compelling example is that not every purchaser is able to get the lower/good price, so the add-on of 6% could be a reflection of this.

Rep. Carter (R-FL): Can you comment on insulin pricing, a major focus for our committee – how do the Medicare plans cover insulin? Kept a theme of transparency.

> **Dr. Mathews:** MEDPAC's recommendation of restructuring addresses drugs that include insulin, helping to make access more affordable.

Rep. Blunt-Rochester (D-DE): Are plans structuring benefits to shift costs more to Medicare, shielding the plans from risks – and does MEDPAC share these concerns?

> **Dr. Mathews:** MEDPAC has even larger concerns than that – it is a pressing problem of plans doing this to not just low-income beneficiaries, but across the board.

Rep. Barragan (D-CA): On drug negotiations, has MEDPAC done a study to see what Americans can save with negotiations? As for minorities, has MEDPAC or CMS done studies on having similar outcomes to the Medicare Part D programs, compared to non-minorities?

MEDPAC has not had an independent study – yet other studies have shown that there is unlikely to be more drug pricing savings without negotiations. There is a potential to look at direct negotiation scenarios. A minority study has not been done – it is a broad endeavor, and MEDPAC would like to get back on this later.

Rep. Gianforte (R-MT): Can you update Congress on hospital accuisititions and consolidation study request for Medicare spending?

> **Dr. Mathews:** There is no update on current studies – the requested work is still ongoing and will be out by the fall.

Rep. Kelly (D-IL): What is the impact of Medicare on the competition amongst biosimilar?

> **Dr. Mathews:** No substantial impact on the price of originator biologics by Medicare.

Rep. Welch (D-VT): Would you be supportive of price negotiations in upcoming legislation? Would arbitration stifle innovation?

> **Dr. Mathews:** MEDPAC has not weighed in on the broader question of negotiation. The current recommendations include binding arbitration, and currently exploring a greater role of this arbitration. There is no belief that arbitration would stifle innovation.