

Opening Statement

Health Subcommittee Hearing: “The Obama Administration’s Medicare Drug Experiment: The Patient and Doctor Perspective”

Rep. Gene Green

May 17, 2016

Good morning and thank you all for being here today.

As we know, the Centers for Medicare and Medicaid Services (CMS), through the Center for Medicare and Medicaid Innovation, recently proposed to test value-driven payment models for prescription drugs under Medicare Part B.

This proposal has garnered significant reaction and response from the provider, patient and pharmaceutical communities.

I appreciate the Chairman for having this hearing today and hope this committee will take the opportunity to examine the proposal’s merits and drawbacks.

While the loudest voices have been opposed to the model outright, it is important to thoughtfully evaluate the issue CMS is attempting to address and look at the proposal with calm and reason.

I appreciate CMS’ consistent goal of strengthening the Medicare program.

However, I have concerns about the scope and size of the proposed demonstration and its potential impact on Medicare beneficiaries’ access to physician-administered drugs, both now and in the future.

I also question how the demonstration may affect physician participation in existing and upcoming delivery and payment reform models.

Currently, Medicare Part B pays physicians and hospital outpatient departments the average sales price or “A-S-P” of a drug plus a 6 percent add-on payment, commonly referred to as ASP + 6.

Medicare pays ASP + 6 for a drug regardless of the price paid to acquire the drug.

MedPAC and others have raised concern that the 6 percent add-on may create incentives to use higher priced drugs when lower priced alternatives are available and appropriate for the patient.

It is difficult to know the extent to which the percentage add-on to ASP influences drug prescribing patterns because few studies have looked at this issue.

Prescription drug spending in the United States was about \$457 billion in 2015, or roughly 17 percent of overall health spending.

In 2015, Medicare Part B spent \$20 billion on outpatient drugs administered by physicians and hospital outpatient departments, which is double the amount spent in 2007.

Beneficiary cost sharing under fee-for-service Medicare Part B is 20 percent with no out-of-pocket limit.

According to the GAO, some seniors and people with disabilities have faced catastrophic expenses, amounting to as much as \$100,000 a year.

The median annual income for Medicare beneficiaries is less than \$25,000 a year, and one in four have less than \$12,000 in savings.

There is a national conversation occurring about the cost of prescription drugs.

I appreciate CMS for attempting to address this issue in part by proposing to test tools to reward value in Medicare Part B similar to efforts in the private sector.

Congress should not ask seniors to pay 20 percent of increasingly expensive therapies without due consideration of whether their money is being well spent.

Health care delivery system is rightfully changing and Medicare should not be left behind.

I am confident that providers want to fulfill their calling and practice medicine, delivering the best care for their patients rather than pad their bottom lines.

Yet, on behalf of seniors and the sustainability of the health care system at large, we cannot put our heads in the sand and ignore trends.

This proposed model is far from perfect and I have serious concerns about many aspects of it.

Recently, I joined members of this Committee in sending a letter to CMS outlining our concerns with the demonstration and urged the agency to address them.

I ask for unanimous consent to submit that letter for the record.

I look forward to hearing from our witnesses about their perspective of the model and concerns we outlined to the agency.

Taking a step back, I want to bring up a related issue that has become part of the conversation around the demonstration, which is that of “prompt pay”.

I have long had an interest in preserving seniors' access to quality care by ensuring Medicare pays at a rate that will retain a robust network of providers.

H.R. 696, also known as the Prompt Pay bill, is a piece of legislation I have introduced with my colleague Mr. Whitfield for several Congresses.

The bill excludes the prompt pay discounts offered by manufacturers to wholesalers from the average sales price for drugs and biologics covered under Medicare Part B.

This became an issue when the Medicare Modernization Act was enacted in 2003.

It reduces the amount doctors are reimbursed for administering treatments and as a result, patients are pushed to more expensive settings for their care.

Reducing the number of options for patients diminishes access, drives up costs in both the short and long term, and is bad policy.

The prompt pay discount has negatively affected patients for many years before sequestration, and whether we adopt legislation repealing, replacing, or otherwise altering the sequester, without adopting H.R. 696, the underlying issue will still exist.

Thank you Mr. Chairman, and again I want to thank our witnesses for being here.

I look forward to a robust discussion about the proposed demonstration.

I yield back.