

Health Policy Update – September 17, 2019

Pelosi Drug Pricing Plan Revealed, Talks Continue on Senate Finance Bill

On September 9, a draft of version of Speaker Nancy Pelosi's prescription drug pricing plan began circulating among Congressional offices. The plan, which the Speaker's office has been working on since the summer, would enable Medicare to negotiate prices on 250 drugs in Part B and Part D which would be chosen based on their cost to the healthcare system and whether they face competition from generics. These negotiated prices would apply throughout the entire U.S. healthcare system, including the prices paid by private insurers.

Taking a page from the Trump Administration's proposed International Pricing Index (IPI), Pelosi's plan would require all public and private payers to pay no more than 120 percent of the volume-weighted average of prices in six countries (Australia, Canada, France, Germany, Japan and the United Kingdom). This index will serve as the basis for Medicare's negotiations. Drug manufacturers that don't reach an agreement with Medicare and raise their prices above that threshold would face a fine of 75 percent of gross sales from the previous year. The proposal would also cap Medicare beneficiaries' annual out-of-pocket costs starting in 2022. Beneficiaries would pay 25 percent of the drug's costs after hitting their deductible. Insurers and drug companies would also have to pay a greater share of beneficiaries' catastrophic costs.

A statement from White House Deputy Press Secretary Judd Deere offered measured support for Pelosi's draft plan, "The President has been focused on this topic since he took office, and he welcomes the Speaker's ideas to help build bipartisan, bicameral consensus for the American people." A more formal proposal from Speaker Pelosi is expected in the coming weeks.

In the Senate, members of the Finance Committee met with industry representatives to discuss a proposal to amend the committee's drug pricing bill to require insurers to offer at least one Medicare Part D plan with up-front discounts for drugs, though no agreement has been reached.

To view a draft version of Pelosi's plan, [CLICK HERE](#).

To view the Senate Finance Committee's bill, [CLICK HERE](#).

Dr. Stephen Hahn Top Contender to Lead FDA, Brad Smith Leading Candidate for CMMI

Dr. Stephen Hahn is reportedly one of the top contenders to lead the U.S. Food and Drug Administration (FDA). Dr. Hahn is chief of radiation oncology and chief medical executive at M.D. Anderson Cancer Center in Houston, Texas.

The FDA is currently led by Acting Administrator Ned Sharpless, who took over after Scott Gottlieb departed the agency in April. Dr. Sharpless previously led the National Cancer Institute and is also reportedly on the shortlist to be nominated as Administrator with the backing of four former commissioners: Drs. Robert Califf, Margaret Hamburg, Andrew von Eschenbach and Mark McClellan.

It was also reported that Brad Smith, co-founder of the Nashville-based palliative care firm Aspire Health, is the leading contender for director of the Center for Medicare and Medicaid Innovation (CMMI). Smith would replace Adam Boehler, who announced his departure in July.

House Small Business Committee Holds Hearing on Prior Authorization Burden

On Wednesday, September 11, the House Small Business Committee held a hearing to examine how utilization management programs like step therapy and prior authorization work and impact small medical practices. The committee heard testimony from:

- Dr. Paul M. Harari, Professor, Chairman, Department of Human Oncology, University of Wisconsin School of Medicine and Public Health; testifying on behalf of the American Society for Radiation Oncology (ASTRO)
- Dr. David R. Walega, MSCI, Associate Professor of Anesthesiology, Chief, Division of Pain Management, Vice Chair of Research, Department of Anesthesiology, Northwestern University Feinberg School of Medicine; testifying on behalf of the American Society of Anesthesiologists
- Dr. John S. Cullen, FAAFP, Family Physician & Partner, Valdez Medical Clinic, LLC; testifying on behalf of the American Academy of Family Physicians
- Dr. Howard Rogers, PhD, FAAD, Owner, Advanced Dermatology, LLC; testifying on behalf of the American Academy of Dermatology Association

In his testimony, Dr. Harari noted that radiation oncologists and cancer patients have been hit particularly hard by prior authorization, stating, “The payment delays and outright denials have created immense instability throughout the field, specifically jeopardizing the continued viability of these free-standing centers and patient access to the high-level care the centers provide.” In 2018, ASTRO conducted a survey of its members in which 93 percent surveyed said their patients face delays in receiving lifesaving treatments, and a third (31%) said the average delay lasts longer than five days.

To view the hearing or read the witness testimony, [CLICK HERE](#).

Coalition of Patient and Employer Groups Urge HHS to End Part B Cost Sharing for Biosimilars

On August 26, more than 20 groups representing patients, employers, and other stakeholders sent a letter to Health and Human Services Secretary Alex Azar asking that the department put an end to cost-sharing for Medicare Part B when a provider administers a biosimilar drug instead of a reference biologic.

“Alignment of incentives across Medicare programs that encourage the use of biosimilars are integral to development of the U.S. market, leading to increased biosimilar usage and unlocking immense savings in the U.S. health care system,” the groups wrote. “As diverse stakeholders who believe that more needs to be done to ensure that patients and taxpayers benefit from the cost-savings potential of biosimilars, we ask you to support reducing or eliminating out-of-pocket costs for Medicare Part B patients taking a biosimilar.”

The letter also notes the slow adaptation of biosimilars in the U.S. market relative to other countries and cites studies showing that currently available biosimilars have the potential to save the country’s health system as much as \$54 billion over the next decade.

Groups that signed the letter include the American Cancer Society Cancer Action Network, the Association of Community Cancer Centers, Employers Health, the Pacific Business Group on Health, the Leukemia and Lymphoma Society of America, and CVS Health.

To view the letter, [CLICK HERE](#).

To learn more about cost savings from biosimilars, [CLICK HERE](#).

Hospital Groups Double Down on Claim that Mergers Lower Costs, Experts Disagree

On September 4, the American Hospital Association released a report claiming hospital mergers result in cost savings for payers and consumers, despite claims from experts to the contrary.

The AHA study, which partly relied on structured interviews from selected hospital CEOs, confirmed the findings of a prior AHA report from 2017. It also analyzed claims data from 2009-2017 and found a 2.3% reduction in annual operating expenses at acquired hospitals and a statistically significant reduction in readmission and mortality rates.

However, the report has come under heavy criticism from economists and health policy experts who have found that mergers typically raise prices and can diminish quality. In the days following the report's release, a group of leading economists held a conference call to specifically discuss issues with the report and its methodology.

"There is substantial and clear evidence that prices increase when there are mergers between close competitors," Martin Gaynor, economics and health policy professor at Carnegie Mellon University, told *Modern Healthcare*. According to the research group Kaufman Hall, the number of hospital and health system mergers have steadily increased — from 38 in 2003 to 115 in 2017.

To view the AHA's report, [CLICK HERE](#).

To view the Kaufman Hall study on hospital mergers, [CLICK HERE](#).

Study Finds Administering Specialty Drugs Outside Hospitals Could Save \$4 Billion Annually

A new study confirmed that administering specialty drugs for chronic conditions such as cancer, rheumatoid arthritis, multiple sclerosis, and others in the outpatient setting rather than in the hospital could reduce drug cost for insurers by as much as \$4 billion annually. The study, which was commissioned and released by the United Health Group, analyzed 2018 utilization and cost data from UnitedHealthcare members with employer-sponsored coverage and found that changing the location of administering specialty drugs to outside the hospital was one of the largest driver of potential savings, delivering as much as \$16,000 to \$37,000 in savings per patient depending on the type of drug.

To read the full study, [CLICK HERE](#).

HHS Announces \$1.8 Billion in State Grants to Combat Opioid Crisis

On September 4, HHS announced it will be awarding \$1.8 billion in grants to help states and local governments address the opioid crisis; the money has already been approved by Congress.

Half of the funding (about \$930 million) will go directly to local communities to provide treatment to individuals with substance use disorders while the other half will go to the Centers for Disease Control and Prevention (CDC) to help states, localities and territories track overdose data and develop strategies on treatment. This round of grants follows the more than \$1 billion in grants awarded in September 2018 to states and communities.

To read the HHS press release announcing the grants, [CLICK HERE](#).

To view a state-by-state breakdown of the grants, [CLICK HERE](#).