



March 13, 2019

The Honorable Anna Eshoo
Chairperson
House Committee on Energy and Commerce
Subcommittee on Health
Washington, DC 20515

The Honorable Michael Burgess, MD
Ranking Member
House Committee on Energy and Commerce
Subcommittee on Health
Washington, DC 20515

Dear Chairperson Eshoo and Ranking Member Burgess:

On behalf of the American Academy of Family Physicians (AAFP), which represents 131,400 family physicians and medical students across the country, I write to share the organization's recommendations for how to manage drug prices and reduce out-of-pocket costs for consumers. The AAFP is also pleased to share its support for several bills under the committee's review.

Managing prescription drug prices for their patients is an important concern for family physicians. Family physicians have a meaningful interest in the drug pricing debate, in part, because of the complexity of care they provide and the fact that the number and intricacy of conditions, complaints, and diseases seen in family medicine is [far greater](#) than those seen by any other physician specialty. Ensuring access to medications is an integral part of a physician's role as an advocate for their patients. Unfortunately, and too frequently, family physicians encounter patients who cannot afford their medications and thus cannot adhere to treatment recommendations. Physicians themselves also face recurrent and burdensome administrative requirements like prior authorizations that create treatment barriers. According to a 2017 American Medical Association [survey](#), 92 percent of physician respondents reported care delays due to prior authorizations and 78 percent reported that prior authorizations can lead to treatment abandonment.

The AAFP has long supported policies to ensure the availability of effective, safe, and affordable prescription medications. In 2017, the AAFP became a member of the [Campaign for Sustainable Rx Pricing](#) (CSRxP), a nonpartisan coalition of nonprofit medical associations, insurers, and hospitals committed to addressing drug price increases by striking a balance between drug innovation and affordability.

Given the public's reliance on generic products, which represent over 89 percent of medications filled, increasing access to these products must be a top priority. Although the Food and Drug Administration has accelerated the generic drug approval process, barriers remain for manufacturing new generic products, resulting in price escalation. An April 2015 Medscape [article](#) cited many factors that cause escalating costs, including strategies that delay or discourage competition by generic drug manufacturers.

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Therefore, the AAFP is pleased to support the following bills that would increase access to generic drugs through enhanced market competition:

- HR 965, *Creating and Restoring Equal Access to Equivalent Samples (CREATES) Act*;
- HR 985, the *Fair Access for Safety and Timely (FAST) Generics Act*;
- HR 938, the *Bringing Low-cost Options and Competition while Keeping Incentives for New Generics (BLOCKING) Act of 2019*; and
- HR 1499, the *Protecting Consumer Access to Generic Drugs Act of 2019*.

In a 2018 [letter](#) to the Department of Health and Human Services, the AAFP highlighted our principles and urged the administration to use its administrative authority to weigh in on legislative proposals that may also strengthen the nation's ability to control drug costs and out-of-pocket spending for patients. The following are select priorities for addressing the nation's drug pricing.

Site Neutral Payments.

Under Medicare Part B and often in Medicaid, physicians are reimbursed comparable amounts for drugs they administer to patients, but the facility fees when drugs are administered at hospitals and hospital-owned outpatient departments are many times higher than the fees charged by physician offices. **The AAFP supports site neutral payment policies for physician-administered drugs and urges Congress to consider further expansion of site neutral payments for outpatient services.** Researchers [found](#) that payments for physician visits at a hospital were \$68 higher on average than for those at stand-alone offices. The authors also reviewed changes in price associated with physicians integrated with hospital systems. In the markets studied, annual outpatient spending increased by \$75 per Medicare patient, "almost entirely owing to price increases rather than changes in utilization."

A [report](#) by the Government Accountability Office (GAO) showed between 2007 and 2013, the number of hospitals that achieved vertical integration with physician practices increased from 1,400 to 1,700, while the number of physicians with a hospital affiliation increased from 96,000 to 182,000. The report indicated Medicare paid \$51 more for midlevel evaluation and management visits performed in a hospital outpatient setting compared to those at independent physician practices. The agency noted, "the inconsistency in Medicare payment policy is not justified. While vertical consolidation has potential benefits, we found that the rise in vertical consolidation exacerbates a financial vulnerability in Medicare's payment policy: Medicare pays different rates for the same service, depending on where the service is performed," the GAO report stated.

Value-Based Drug Pricing

In March of 2016, CMS proposed a value-based drug pricing demonstration project that establishes a common reimbursement for Medicare Part B drugs, implements purchasing agreements with drug manufacturers based on drug effectiveness, and includes clinical decision support tools. The transformation of our health care system requires fresh perspectives and new ideas regarding payment and delivery of health care services. The AAFP [applauded](#) CMS' efforts to apply common sense, value-based payment (VBP) principles to the delivery of physician-administered pharmaceutical and biologic treatments. VBP involves linking payment for drugs to patient outcomes and cost-effectiveness rather than volume of sales. **Physicians, hospitals, and other Medicare providers are**

aggressively pursuing VBP models, and HHS should explore the applicability of VBP principles and models to the pharmaceutical industry.

Medicare Negotiation Authority

According to a 2016 [article](#), from 2004 to 2014, Medicare's share of U.S. drug expenditures increased from 2 percent of total U.S. drug spending, or \$193 billion, to 29 percent, or \$298 billion. Unfortunately, the 2003 *Medicare Modernization Act* prohibits CMS from engaging in drug pricing negotiations. **The AAFP supports policies to ensure Medicare and Medicaid prescription drug programs can best take advantage of recent developments in value-based purchasing so all parts of the U.S. health care system benefit from market-based negotiating efforts to lower drug prices.** Researchers have also concluded the federal government could save \$15.2 billion to \$16 billion annually if it negotiated with drug manufacturers and achieved the same prices as those paid by Medicaid or the Veterans Health Administration.

Transparency

Transparency policies do not directly lower drug costs but may provide more data that could help federal agencies and policy makers increase accountability. Greater transparency would also allow physicians and patients to make more informed treatment choices. In recent years, public and congressional accountability measures identified that EpiPen had been misclassified as a generic drug for years within the Medicaid Drug Rebate Program. This issue highlights the importance of having strong transparency policies in place. This is reflected in the fact that 30 states have begun to review their own transparency laws. The AAFP supports pricing transparency, including for off-patent and generic drugs.

Six Protected Drug Classes

In 2014, the AAFP [opposed](#) a CMS rule that would restrict patients' access to necessary medications. The CMS proposal would have removed antidepressants and antipsychotics from the list of medications that are required to be included in all Part D formularies. Medicare formularies have included six protected drug classes (anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals, and immunosuppressants for the treatment of transplant rejection) since 2005, and the AAFP opposes any change to their status that could limit a patient's access to physician-prescribed medications. We recognize there may be noteworthy proposals under consideration that may result in lower costs but urge the Administration to prioritize patient access to these essential drugs.

Thank you for the opportunity to comment on current drug pricing policies. For more information, please contact Sonya Clay, Government Relations Representative, at 202-232-9033 or sclay@aafp.org.

Sincerely,



Michael L. Munger, MD, FFAFP
Board Chair