Statement of

Nancy Davenport-Ennis
Founder and CEO
National Patient Advocate Foundation

on

Examining Reforms to Improve the Medicare Part B Drug Program for Seniors

before the

United States House of Representatives Committee on Energy & Commerce
Health Subcommittee

on

June 28, 2013

Chairman Pitts, Ranking Member Pallone and members of the subcommittee, thank you for the opportunity to testify today on ways to improve Medicare Part B, with particular emphasis on the Part B Drug program. My name is Nancy Davenport-Ennis, and I am the Founder and CEO of the National Patient Advocate Foundation (NPAF) and the Patient Advocate Foundation (PAF). I would like to thank the subcommittee for working to protect patients and hope you will continue to support the millions of Americans who endure chronic, debilitating and life-threatening illnesses and who struggle to obtain access to the health care services and medicines they need.

I am here to speak about the long overdue need to improve Medicare Part B. Each of us has heard from patients and constituents who have heart-rending stories of denied access to care. Burdensome out-of-pocket costs make health care inaccessible for Medicare beneficiaries. After 17 years of resolving health care access issues in 750,000 patient cases, I can attest with certainty that patients who struggle to manage chronic, debilitating and life-threatening diseases require access to a physician who knows the patient, who knows the disease, and who understands the particular struggles the patient is trying to manage.

What I would like to stress this morning is that Medicare patients who reach out to PAF for help come from all 50 states and report difficulties with Medicare Parts A and D, as well as B. These difficulties include medical debt crises and cost-of-living issues, reported by 29.5 percent of patients, the most frequently reported issue in 2012. Debt crisis and cost of living issues include the inability to afford transportation, make rent or mortgage payments, meet basic food and nutritional needs, and pay utility bills. These patients represent the most vulnerable among us.

Of the 109,147 patients PAF served in 2012, 23.1 percent are Medicare beneficiaries. In 2011, PAF served 103,000 patients, of whom 28.5 percent were Medicare beneficiaries. As reported in PAF's 2012 Patient Data Analysis Report[1], the vast majority of Medicare patients – 72.6 percent – who reached out to our organization in 2012 for assistance in paying for care had some form of cancer. The second most frequently reported category of disease, affecting 11.9 percent of PAF patients in 2012, includes chronic conditions such as diabetes, osteoporosis, chronic obstructive pulmonary disease (COPD), fibromyalgia, hepatitis and degenerative disc disease, among others.

Coverage issues were reported by 24.4 percent of PAF Medicare patients. Difficulty meeting pharmaceutical co-payment requirements was reported by 21.2 percent of PAF Medicare patients. An analysis completed by PAF of nine national copay programs in the country found that $447.7 million of annual support was made available to patients. Even at this level of support, countless beneficiaries may not qualify for assistance, or their disease silo is not funded. While copay programs provide an invaluable service to Medicare beneficiaries, fundamental changes to out-of-pocket requirements must be made for Medicare benefits to align more closely with those available in insurance products in the commercial market.

Unfortunately, Medicare beneficiaries are having an increasingly difficult time finding and retaining access to providers who have an intimate knowledge of the patients and their conditions. Reductions in Medicare reimbursement to physicians over the past several years have made it difficult to maintain their practices within the community or to continue to accept Medicare beneficiaries as patients. The difficulties include the following:

[1] Patient Advocate Foundation. Patient Data Analysis Report. 2012. 16th Edition.

- The vagaries of the sustained growth rate (SGR) adjustments have made planning uncertain and unpredictable for physician practices.
- Medication reimbursement based on Average Sales Price (ASP) has significantly increased the cost of inventory and reduced compensation for administration of Part B drugs.
- The factoring of prompt pay discounts – which is a matter between manufacturers and wholesale distributors – into the ASP calculation has further cut physician reimbursement for Part B drugs artificially by about 2 percent.
- The President's 2014 Budget Proposal would cut Part B drug reimbursements from ASP + 6 percent down to ASP + 3 percent.
- The sequester effectively has cut Part B drug reimbursements to physicians by 2 percent for medications and for administrative services since April 1.

The following cases reported to PAF case managers illustrate shifts in sites of care for Medicare Part B patients from practice settings to hospital outpatient settings:

1. GA – Georgia Cancer Specialists is a national leader in advanced cancer treatment and research with 46 physicians and 27 locations. On April 1, 2013, Georgia Cancer Specialists joined the network of Northside Hospital due to budget cuts. They have twenty free-standing physician practices located within a 35-mile radius of Northside Hospital that utilize the hospital's billing system. The seven remaining free standing offices (Blue Ridge, Atley, Hawkville, Zononi) are rural offices located outside the 35-mile radius range and routinely send Medicare and Medicare Advantage patients to the hospital setting when the Georgia Cancer Specialists are unable to locate financial support through co-pay assistance, drug card discounts or hardship programs.

2. GA – Northeast Georgia Diagnostic Clinic serves patients in the Gainesville and the surrounding communities of the Northeast Georgia region. They have three offices serving 200-250 patients a day through their seven providers. Their practice has four oncologists and 3 Rheumatoid Arthritis specialists. For anyone needing infusions with Medicare only (and unable to secure supplemental support such as Co-Pay) the patients are shifted to the hospital setting at Northeast Georgia Medical Center.

   In one example, the average out-of-pocket cost for a colon cancer patient is around $500-600 a treatment. One patient was transferred to the hospital setting from the clinic, where his costs tripled for the infusion charge. Despite the increased cost, the patient no longer has access to a trained oncologist.

   A second example involves Rheumatoid Arthritis patients who need Remicade or Rituxan. This facility now sends patients to the hospital because the cost to infuse is too costly for the clinic to absorb. Many patients in Part B are often redirected to Part D drugs that are on specialty tiers requiring a co-insurance from 25 percent to 66 percent. Many of these patients abandon their prescription due to their inability to pay the out-of-pocket cost. If patients in Part B, who are also being prescribed Part D drugs, had a process available to cap out-of-pocket expenses in Part

D to 25 percent, the abandonment rate could drop precipitously. At $200 out-of–pocket cost, the abandonment rate is 25 percent and increases appreciably with each increase in co-insurance.

3. OH - Zangmeister Center serves 70-90 patients daily with chemotherapy through their 11 oncology/hematology physicians. The reductions in Medicare payments are particularly devastating to clinics like Zangmeister Center in Columbus, Ohio, where 50 percent of patients are Medicare beneficiaries. Like many of their peers, physicians at Zangmeister Center are offering critical cancer drugs at break-even or negative reimbursement levels. In fact, they currently provide at least 32 life-saving drugs for which they do not receive full reimbursement. In other words, doctors are forced to pay out of their own pocket if they wish to provide these life-savings drugs to their patients. This is simply unsustainable for the facility and thousands of other community cancer clinics across the country. As a result, the sequester cuts have forced Zangmeister Center and many similar community centers to advise their Medicare patients to seek care elsewhere.

4. NM – New Mexico Cancer Center is an independent physician owned practice with three other satellite offices. They began sending patients in need of chemotherapy infusion to the hospital setting as of April 1, 2013 due to budget constraints.

5. KS – The McKesson Specialty Health /US Oncology Network has expressed its need to move patients into a hospital setting due to budget cuts.

6. IN-- Dr. Koneru of Cancer Care of South Indiana merged with Premier Healthcare Group due to budget cuts.

7. PA – A 70 year-old breast cancer patient was transferred from the Allegheny Cancer Center to the West Penn Hospital after the local clinic was unable to continue to accept her Medicare Advantage Plan, Freedom Health, for her chemotherapy treatment.

8. CO- A 75 year-old ovarian cancer patient was unable to locate a local physician in and so was forced to travel to Denver, 30-45 minutes each way.

9. TX – A provider office could no longer o treat a patient due to unpaid medical co-insurance. The patient was sent to the Medical City Dallas Hospital for administration of her chemotherapy.

10. TX – A 77 year-old ovarian cancer patient, who came to PAF for help, was receiving chemotherapy treatment at the Medical City Hospital in Dallas. Her treating doctor could no longer treat her in his office due to budget cuts. She was already on a $5-a-month payment plan to pay back outstanding medical debt and will be in chemo the rest of her life.

As a matter of fairness, Medicare Part B beneficiaries have a right to receive the same benefits and access to quality care that other health insurance enrollees receive. For example, health benefit plans available in the commercial market include a stop-loss provision that limits out-of-pocket costs after a

threshold has been reached. Part B includes no such provision; beneficiaries continue to pay 20 percent out-of-pocket for every single Part B service provided in perpetuity, with no cap.[2]

This limitless payment requirement presents a significant burden for beneficiaries with multiple, chronic conditions. This is particularly true for those who reach out to PAF: two-thirds of PAF Medicare beneficiaries had annual household incomes of $23,000 or less. Under a traditional insurance plan, at some point the 20 percent liability would end, and the insurance benefit would assume the cost.

Formulary restrictions under Medicare Part B and D further impede beneficiaries' access to optimal care. Medicare patients deserve the proper medication at the right time at a reasonable level of cost-sharing.

Making matters worse for patients, displacement from care in community centers will increase reliance on urban hospital care, where the annual cost of receiving chemotherapy in a hospital outpatient setting is $6,500 higher than receiving care in a physician's office. Additionally, patient co-pay amounts are approximately 10 percent higher for hospital outpatient care, which totaled more than $650 per patient per year.[3]

Furthermore, the perception that radiology is a huge driver of health care costs is the primary reason for the seemingly never-ending string of imaging-related cuts. Radiology has experienced $6 billion in Medicare cuts for imaging services since 2006.[4]

Let me close with two recent examples to illustrate our concerns about patient access. Recently, PAF received a call from a Medicare beneficiary who had been diagnosed with a rare form of Non-Hodgkin's Lymphoma that caused severe hemolytic anemia, which requires almost daily lab tests and possible platelet infusions. The closest hospital that could provide these services was 40 miles away, and the patient's family was struggling to afford the transportation costs. Traveling 80 miles a day to receive necessary care adds severe strain to a patient's quality of life, as they are managing a devastating diagnosis.

In 2012, PAF was contacted by a 65 year-old Medicare beneficiary who had been diagnosed with throat cancer. The patient was in severe pain and was having difficulty affording his medication. After speaking with a PAF case manager, the reason for his difficulties became clear: the patient lived 300 miles from his cancer treatment center, and his transportation costs were leading to medical debt crisis. With an annual income of $40,000 per year, the patient had an extremely difficult time affording his medication, transportation and cost of living.

These Medicare patients need Congress' help to ensure that the health care they require is as conveniently located as possible. Congress must correct the way the sequester is applied to Medicare Part B drug reimbursements and eliminate these cuts that cruelly punish cancer patients. Further, Congress should enact H.R. 800, which removes prompt pay discounts from the calculation of Medicare reimbursement rates to make the ASP formula more closely resemble average costs. Additionally,

[2] Medicare.gov. http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html#collapse-4809
[3] Milliman, Inc., NY. "Site of Service Cost Differences for Medicare Patients Receiving Chemotherapy." October 19, 2011.
[4] Radiology Leaders Criticize Congressional Imaging Cuts. March 01, 2013. http://rsna.org/NewsDetail.aspx?id=8565

Congress stop incentivizing the shift to the hospital outpatient department setting. ASP can only work if it is fair and accurate, and it is up to Congress to ensure that this is the case.

The following recommendations are from PAF professional case management staff, who routinely serve Medicare beneficiaries:

- Launch a national education campaign to enhance enrollment in Medicare Part B and highlight the penalty that is assessed to those beneficiaries who do not have credible coverage and delay enrollment past their initial eligibility date.

- Cap out-of-pocket expenses for those Medicare beneficiaries who simultaneously rely upon Part B and D benefits to enhance adherence to treatment protocols and improve outcomes in disease management. The 20 percent co-payment for Medicare Part B services and products, in combination with the demands of co-insurance for drugs purchased through Part D, with payment required in full at time prescriptions are filled, result in excessive abandonment rates and destabilization of household resources and individual budgets.

- Establish an annual out-of-pocket maximum for Medicare beneficiaries that is consistent with the commercially insured market from which these beneficiaries have had insurance throughout their working lives. Out-of-pocket caps allow planning for utilization of resources to manage illness across their later years.

- Improve Medicare reimbursement to providers so that research hospitals accept Medicare patients with Medicare Advantage plans. . Currently, many of our leading research hospitals will not accept Medicare Advantage plans due to insufficient reimbursement for services and medical supplies.

- Modify Specified Low-Income Medicare Beneficiary (SLIMB) support to more closely align with services that can be paid for through Qualified Medicare Beneficiary. Currently, SLIMB is limited to payment of premium only however, these beneficiaries need support in multiple areas of health care.

The overarching message for Congress to consider is that Medicare Part B should minimize beneficiaries' financial risk over time. This principle will be an increasingly important element of the program as the baby boom population continues to reach Medicare eligibility. I urge you to give careful consideration to the impacts of the sequester, and work to protect the most vulnerable in this country and prevent any further cuts to community cancer care.

Thank you again for the opportunity to testify this morning. I would be happy to address any questions you might have.