



TESTIMONY OF

UAW RETIREE MEDICAL BENEFITS TRUST

by

ALAN REUTHER, LEGISLATIVE CONSULTANT

On the subject of

THE COST OF RISING PRESCRIPTION DRUG PRICES

Before the

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

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I. Introduction

Mr. Chairman, Members of the Committee. My name is Alan Reuther. I am the Legislative Consultant for the UAW Retiree Medical Benefits Trust (“Trust”). We appreciate the opportunity to testify today on the subject of the cost of rising prescription drug prices.

The Trust provides health care benefits for 656,000 retired UAW members of General Motors, Ford and Chrysler, along with their eligible dependents. It is one of the largest non-governmental retiree health care plans in the United States. The Trust is independent from the auto companies and the UAW, and is governed by an 11-person committee.

The Trust was established through collective bargaining agreements and court approved class action settlement agreements between the UAW and the three U.S. auto companies under which all of their retiree health care liabilities were transferred to the new independent Trust (which is technically a Voluntary Employee Beneficiary Association (VEBA) under the Internal Revenue Code). These agreements established fixed and capped contribution levels that the auto companies were required to make to the VEBA. Under the agreements, the auto companies have no further obligation to contribute to the Trust. It must live with the assets it received and has no future sources of funding. The Trust must therefore take an active role in managing its health care expenditures in order to ensure that it can continue to provide the best possible health care benefits to the retirees with the fixed resources available to it.

About 80% of the Trust’s members are enrolled in Medicare. Nearly all of the Medicare enrollees are in a stand-alone Employer Group Waiver (EGWP) Medicare Part D plan maintained by the Trust. Attached to this testimony is a fact sheet that provides additional detail on the Trust’s membership and how it provides health care benefits to retirees over the course of their lives.

Last year the total health care expenditures for the Trust were \$4.2 billion. Of that, \$2.0 billion – almost half - were spent for prescription drugs. Like most health care plans, the Trust’s spending on prescription drugs has been increasing

rapidly in recent years, rising 55.7% from 2013 to 2018. This dramatic increase in spending on prescription drugs will inevitably reduce the resources available to the Trust to address other important health care priorities for its membership.

Of course, these dynamics are not unique to the Trust. Other health care plans are experiencing the same abrupt price increases, with the same types of difficult resource allocation challenges that flow from them.

For these reasons, the Trust strongly urges this Committee and Congress as a whole to take action to restrain the skyrocketing costs of prescription drugs. We believe this would help individual consumers, health care plans like the Trust, as well as Medicare and Medicaid. In our judgment, there is no single magic bullet. Rather, we urge you to consider a range of steps to curb prescription drug costs.

II. Insulin

From 2014 to 2017, the Trust's single largest drug spend was for insulin and GLP-1 receptor agonist & long-acting insulin combination. In 2018, these insulin products represented our second largest drug spend (surpassed by only very expensive oncology medications). In 2018, we spent \$235.2 million on insulin. About 155,000 Trust members have diabetes, and 50,000 have prescriptions for insulin.

Of particular concern, the Trust's spending on insulin increased by 51% between 2013 and 2017. This was despite the fact that insulin usage declined by 4% during that period! This dramatic increase in spending on insulin has largely been caused by the significant price increases for insulin generally, and the increasing utilization of the more costly GLP-1 type of insulin combination. We believe other health care plans, covering retirees and active workers, have likely experienced similar surges in their spending on insulin related products.

As has been well documented, the average price of insulin in the United States nearly tripled between 2002 and 2013. Between 2012 and 2016, the average list price of insulin increased 15-17% per year. While the utilization/prescription volume for insulin has remained flat, the gross sales for insulin have increased significantly as a result of the dramatic price increases. In stark contrast,

European countries have been able to cap or even push down their prices for insulin.

We have recently heard heart-rending stories of individual patients who have jeopardized their health by rationing their doses of insulin because they cannot afford its high cost. These stories are truly shocking.

The Trust has worked hard to insulate our members from the sharp increases in prices for insulin and to prevent the rationing of insulin doses. It has maintained low copayments on insulin thus far. But like other health care plans, the Trust faces serious challenges because of these exorbitant price increases.

The Trust has been heartened by the numerous articles and news stories that have recently appeared highlighting the problems posed by high insulin prices. We also have been encouraged by the recent actions of several Congressional Committees to seek information from drug companies about insulin prices. In particular, we applaud the recent bipartisan statements from Representatives and Senators expressing concern about the problems posed by high insulin prices, and expressing determination to do something about it.

In our judgment, addressing the problem posed by high insulin prices will require both long term and short-term strategies. In the long term, the solution clearly is to foster greater competition among the manufacturers of insulin. Currently there are three producers of insulin (Eli Lilly, Nordisk, and Sanofi) selling in the United States. They have been able to use their market power to charge much higher prices.

The Trust believes there are a number of steps Congress and the Administration could take to foster greater competition among insulin manufacturers. We applaud the recent action by the FDA to reclassify insulin as a biologic product. We are hopeful this will facilitate the development of lower cost biosimilar versions of insulin. However, we urge Congress and the Administration to take further steps to speed up the process for approving biosimilars. This includes:

- Prohibiting “pay-for-delay” agreements that delay the entry of lower cost drugs;

- Reducing the exclusivity period for brand and specialty medications;
- Ensuring that “interchangeability” determinations do not present an unreasonable barrier (especially since many states confine substitution to biosimilars determined to be interchangeable);
- Counteracting abuses of the drug patent system (e.g. companies continually getting new patents for minor changes in their product; companies patenting the delivery technologies for drugs, such as autopens, that do not relate to the substance being injected).

While helpful and important, all of these actions will necessarily take time before they have an impact on the price of insulin. Given the magnitude of the immediate problems facing patients and health care plans, the Trust believes it is also important for Congress and the Administration to take steps that will have a short-term impact on lowering the price of insulin. There are a variety of actions that could accomplish this, including:

- Linking the price of insulin to lower international prices (the Trump administration has a similar proposal for Part B drugs);
- Linking the price of insulin to the prices currently negotiated by DOD, VA, and other federal agencies through the federal supply schedule and federal ceiling prices (which provide discounts of 55-73%);
- Allowing Medicare to broadly negotiate prescription drug prices.

If need be, Congress and the Administration could take these types of steps on an interim, transitional basis, to provide relief until the longer-term actions are able to lower prices by fostering greater competition in the insulin market.

III. Generic Drugs

The Trust has worked hard to increase the percentage of our members who use lower cost generic drugs, rather than higher priced brand name medications. This includes providing incentives for members using generics. As a result of these efforts, the generic dispensing rate for Trust members increased from 70% in 2010 to 89.2% in 2018. This represents one of the major ways the Trust has managed its health care expenditures.

However, recently we have become concerned about spikes in the prices for some generic drugs. In 2015, the prices for generic drugs increased 10%. Since then, the Trust has continued to experience significant price increases for various generic medications. Certain medications experienced unexplainable price increases. For example, the price of digoxin (a generic heart medication) shot up from \$131 for a 30-day supply to \$989. The price for tetracycline (an antibiotic) jumped from \$31 to \$450. In other cases, there were spikes for specific dosages of generic medications, but not for other dosages of the same active ingredient.

Of particular concern, spending for high priced generics (costing more than \$75 for a 30-day supply) has increased enormously. For the Trust, these high-priced generics represent 68.8% of our overall spending on generics, even though they only represent 6.3% of the generic prescriptions filled for our members. This is despite the fact that over 70% of these high-priced generics have safe and effective generic competitors that average less than \$30 per fill.

We are also concerned about the enormous price differences that have arisen between generic capsules versus tablets, particularly with extended release tablets. For example, even though they have the same medical impact, Tizanidine generic tablets (a muscle relaxer) cost \$2.18, whereas the generic capsules cost \$125.61. Venlafaxine generic capsules (for depressive and anxiety disorders) cost \$3.14, whereas the generic tablets cost \$251.09.

The Trust believes there are a number of steps that Congress and the Administration can take to address these problems. These include:

- Cracking down on abusive actions by generic manufacturers to take advantage of short term supply problems;
- Moving proactively to ensure there are sufficient producers of generics.

IV. Biologics/Specialty Drugs

Spending on biologic and specialty drugs also represents a rapidly rising share of the Trust's total spending on prescription drugs. In 2018, the Trust spent \$778 million on these medications, about 38% of our overall drug expenditures. Of

particular concern, spending on these medications has increased from 11% of our overall drug expenditures in 2010 to 38% in 2018.

As is well known, many of these biologic and specialty drugs carry extremely expensive price tags. We therefore expect spending on these medications to continue to rise in the coming years. The current new-to-market pipeline and recent publications predict the specialty drug spend will increase to 50% of total plan costs by 2021.

To counteract this trend, the Trust believes it is important for Congress and the Administration to take steps to limit the price of biologics and specialty drugs, and to encourage the introduction and availability of lower cost biosimilars. The range of steps that we outlined in our earlier discussion of insulin would all be important in this context as well. We also urge Congress to pass the CREATES Act to address REMS abuses. Furthermore, Congress and the Administration should take steps to educate physicians and otherwise encourage them to increase the uptake of lower cost biosimilars.

In addition, the Trust specifically urges Congress to consider legislation on direct-to-consumer advertising for biologics and specialty drugs. The advertising gap gives patients an incorrect impression about the superiority of brand name biologics and specialty drugs.

V. Part B Drugs

An increasing percentage of drug spending under Medicare is for drugs covered under Medicare Part B (rather than Part D). This often involves medications that are infused or are clinician-administered injections. In general, the Trust is seeing more high cost new specialty type therapies coming to market by being delivered under Medicare Part B.

The Obama Administration and the Trump Administration have both recognized that the current system for reimbursing drugs under Part B provides an incentive for prescribers to choose more-costly therapeutic alternatives. Both administrations put forth proposals that generated considerable controversy. Despite this, the Trust urges the Trump Administration and Congress to find a way

to move forward with changes to Part B that will eliminate this bad incentive. Rather than the current reimbursement system that is keyed off the Average Sales Price plus a 6% add on, we believe it would be better to have a set amount or to implement one of the alternatives proposed by MedPAC.

One advantage of moving away from the Average Sales Price system for reimbursing Part B drugs is the impact on the 20% coinsurance that individuals are responsible for under Medicare. Because Part B drugs are some of the most expensive medications, this 20% coinsurance can be extremely burdensome for individuals (and for health care plans that cover these expenses). Unlike in Part D, there is no “catastrophic coverage level” in Part B. This means individuals (or their health care plans) will be responsible for these costs indefinitely during a course of treatment or for as long as the individual receives that medication.

In addition to changing the reimbursement system for Part B drugs, the Trust believes a solution to this cost-sharing problem would be to change Part B cost-sharing from a coinsurance to a copayment. This would make the cost sharing more transparent to patients and physicians, and easier to administer. It would also help ensure that patients receive some of the savings generated by any new Part B reimbursement system.

VI. Flexibility in Plan Formularies

The Trust believes it is important for Medicare Part D plans to have flexibility in managing their drug formularies. This can be a very important strategy for reducing prescription drug costs, both for consumers and for health care plans.

There are many examples where flexibility in managing a plan’s drug formulary could be important in reducing costs. These include:

- Enabling pain management programs in a group Part D plan to mirror the programs for pre-Medicare group members in order to ensure safety and consistency as members age into Medicare;
- Updating the formulary to keep pace with recalled medications;

- Being able to temporarily flex coverage to accommodate medication gaps;
- Updating coverage management criteria to align with clinical practice recommendations due to updates to national/international guidelines (i.e. American College of Rheumatology, Global Initiative for Chronic Obstructive Lung Disease, etc.).

Because of procedural requirements, it generally takes longer to implement utilization management tools under Medicare compared to a non-Medicare population. The Trust urges Congress and the Administration to take steps to reduce this disparity, so that Part D plans can move as quickly and effectively as commercial, non-Medicare plans. We believe this can be important in situations where the FDA approves new indications for drugs, and cases where there is new evidence about the relative effectiveness of different drugs. We believe allowing greater flexibility for Part D plans in implementing utilization management tools can help to lower drug costs for patients, for health care plans, and for Medicare.

The Trust recognizes that there is a legitimate concern that some Part D plans might abuse this by engaging in “bait and switch” tactics – that is, getting individuals to enroll in their plans by promising the availability of certain drugs, but then later curtailing or eliminating their availability, or sharply increasing their cost-sharing. This, of course, is unacceptable. We would note, however, that the danger of this type of abuse is not present in group Part D plans (i.e. Employer Group Waiver Plans), like the Trust, where the members covered by the plan are determined in advance and there is no solicitation of new members. The Trust submits that Congress and the Administration should be able to take steps that will safeguard against any “bait-and-switch” abuses, while still allowing EGWPs and other Part D plans to have more flexibility to engage in legitimate, beneficial uses of utilization management tools in their drug formularies.

VII. Conclusion

In conclusion, the Trust appreciates this opportunity to testify on the subject of the cost of rising prescription drug prices. We believe there is an urgent need for

Congress and the Administration to take meaningful steps that will help to reduce the prices for prescription drugs – for insulin, generics, biologics and specialty drugs, Part B medications, and drugs covered under Part D. There are a wide range of actions that would be helpful. In our judgment, if these actions are implemented, they could have a major impact in helping to save money for individuals, health care plans, and for Medicare.

The Trust looks forward to working with this Committee as you consider these important issues. Thank you.

The UAW Retiree Medical Benefits Trust (the “Trust”) provides health care benefits for retired UAW members of General Motors, Ford, and Chrysler, along with their eligible dependents. This arrangement was made possible through a provision in the 2007 collective bargaining agreements between the UAW and the three auto companies under which all of the retiree health care liabilities were transferred to a new independent Voluntary Employee Beneficiary Association (VEBA), also known as “the Trust.” The Trust is independent from General Motors, Ford, Chrysler, and the UAW, and is governed by an 11-person Committee.

Who We Serve

Currently, the Trust provides health care benefits to 656,271 persons. Greater than 80% of the Trust enrollees are enrolled in Medicare. Of those members, greater than 65% are enrolled in an MA HMO or MA PPO plan nationally. Nearly all of the Medicare enrollees are in a Medicare Part D plan.

The Trust has members in every U.S. state. Forty percent of Trust members live in Michigan. Twelve percent of Trust members live in Ohio. Eight percent of Trust members live in Indiana. The next three states – Florida, New York, and Missouri – each have four percent.

The Trust covers members from retirement through the end of their lives. In addition to current members, approximately 73,000 active workers and their eligible dependents will have access to Trust coverage when they retire. The Trust provides coverage for the retired member, spouse and eligible dependents. The diversity of covered lives spans several generations.

Established January 1, 2010

Membership

Trust Membership	
Total Current Membership	
656,271	
Medicare	Non-Medicare
527,014	127,066

As of January 2019

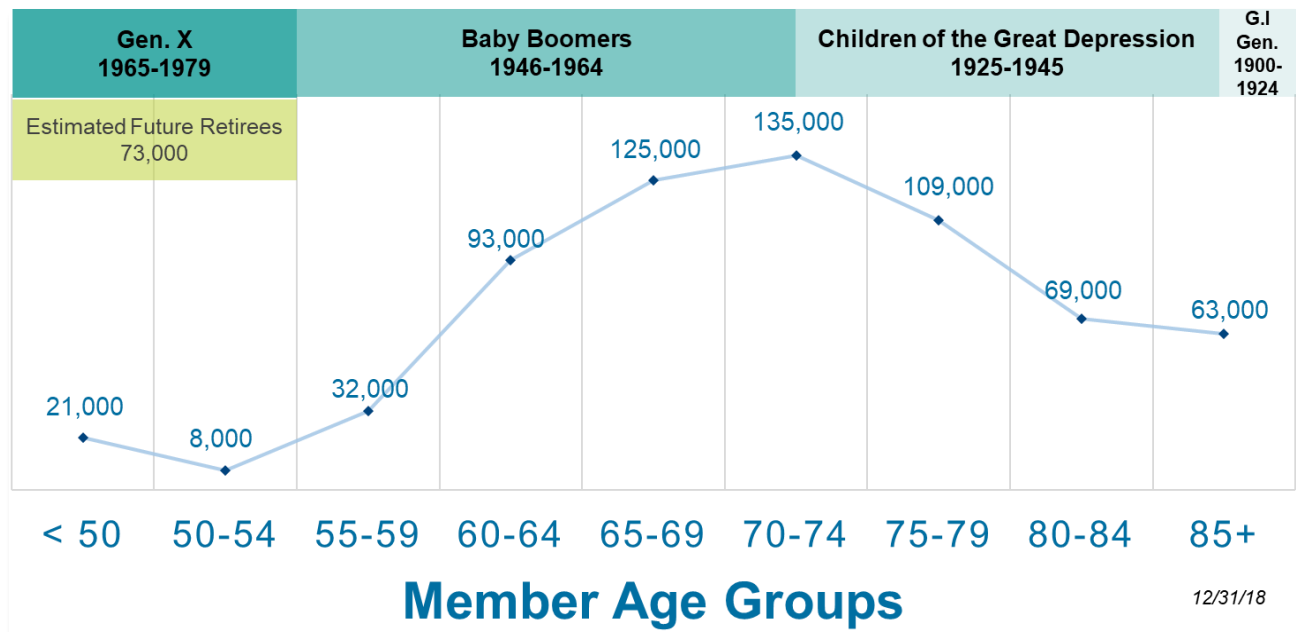
Headquarters Detroit, MI

Mission To provide every member with health benefits and the opportunity to achieve their best quality of life.

Annual Health Care Spend \$4.2 Billion

Pharmacy Spend \$2.0 Billion

January 2018



Focusing on Retiree Health Care

The multigenerational nature of our population requires that the Trust actively work with health plans, providers, and enrollees to create a new health care model, enhancing quality care in all stages of life. Retiree enrollees are provided with information to make decisions and be active participants in their health care. The Trust is focused on providing the best value in terms of quality, cost, and patient experience for its enrollees in all stages of their lives.

More specifically, the Trust has modified its plan design and plan offerings to focus on the needs of its population. The Trust instituted a formulary with tiered copays to provide access to a broad range of prescription drugs, while emphasizing lower cost alternatives. The Trust has increased access to care in adding coverage of primary care and specialist office visits, urgent care and retail health clinics. The Trust covers a wide range of preventive screenings, many of which are recommended for older adults, at no cost-sharing. The Trust also provides coverage for dental, vision, hearing, and supplemental programs to support the members health needs.

Over the years the Trust has increased its partnership with health insurance carriers offering Medicare Advantage plans. For Trust members, these plans offer expanded benefits (such as coverage of specialist office visits, additional preventive services, and health club memberships) and increased care coordination. The Trust believes these plans offer real value for Medicare members.

Our Members Contribute to their Health Care Costs

Members share in the cost of their care. The costs of health care have increased substantially over the years, while our members' retirement incomes remain fixed. The Trust does its best to cushion any increase in costs where appropriate for high-value, needed care.

The Trust believes every member should have access to quality affordable healthcare that recognizes their unique needs as they pursue their goals for health at every stage of life. We are committed to being responsible stewards of Trust assets to provide high quality health care today and in the future.

2019 Member Cost Share

- Monthly contributions \$17 single / \$34 family
- Deductible \$400 single / \$675 family
- Out-of-pocket Max \$800 single / \$1,475 family
- PCP Office Visit Copayment \$25
- Specialist Office Visit Copayment \$35
- Urgent Care Copayment \$50
- Emergency Room Copayment \$125
- Three-tier pharmacy copayment (retail (30-day supply) / mail order (90-day supply))
 - ◆ \$14 / \$24
 - ◆ \$45 / \$85
 - ◆ \$115 / \$230