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BY HEALTH AND HUMAN SERVICES SECRETARY ALEX AZAR

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PARTICIPANTS:

Introduction:

PAUL GINSBURG
Director, Center for Health Policy at Brookings
USC-Brookings Schaeffer Initiative for Health Policy

Keynote Address:

ALEX AZAR
Secretary
U.S. Department of Health and Human Services

Fireside Chat:

ALEX AZAR
Secretary
U.S. Department of Health and Human Services

PAUL GINSBURG
Director, Center for Health Policy at Brookings
USC-Brookings Schaeffer Initiative for Health Policy

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P R O C E E D I N G S

MR. GINSBURG: I'm Paul Ginsburg. I'm director of the USC-Brookings Schaeffer Initiative for Health Policy and I welcome you to Brookings.

I'm pleased to host HHS Secretary Alex Azar to discuss the administration's new proposal to lower prices for Medicare Part B drugs, which are drugs administered and billed by physicians rather than dispensed by pharmacies. Aspects of this proposal mirror one from the Obama administration that was not implemented due to opposition in Congress and a number of proposals from MedPAC over the last few years. The proposal to directly reduce prices to the average and other developing countries has not been proposed before.

The event will begin with Secretary Azar's presentation about the new proposal, then I will join him on stage to engage in a conversation about the proposal. And after that, he will take some questions from the audience.

Alex Azar was sworn in as President Trump's Secretary of Health and Human Services in January 2018. His current tenure at HHS is his second tour of duty at the Department after serving as general counsel and then deputy secretary in the 2000s. He has spent his career working in senior healthcare leadership roles in both the public and private sectors, the latter including time at Eli Lilly and Company.

It's a pleasure to introduce you to the 24th U.S. Secretary of Health and Human Services, Alex Azar. (Applause)

SECRETARY AZAR: Thank you, Paul. Well, thank you, Paul, very much for that introduction and it's great to be here at the Brookings Institute today because there are few places on Earth where people get as excited as you do here on discussing how to fix complicated, broken government programs. (Laughter) I'm so

pleased to say that's what we're here to do today.

All of you understand the importance of dynamism and reform in government and the need for commonsense reforms to improve our largest government programs like Medicare. That's what President Trump put forth yesterday at HHS, a long overdue reform for how Medicare pays for some of the most costly drugs the program covers.

One of the reasons that reforms like this don't come along very often is that broken programs are protected by the special interests they serve. With apologies to the political scientists in the room, you do not need a Ph.D. to know that. In Medicare Part B today the government gets the bill for the drug and we just blindly pay it. Oh, plus a 6 percent markup for the provider who administers it. There is no negotiation and the payment mechanism actually encourages the prescribing of more expensive drugs.

Again, with apologies to the economists in the room, you don't need a Ph.D. to understand why this program is going to be the fastest growing part of Medicare. Indeed, from 2011 to 2016, per beneficiary spending on Medicare Part B drugs rose 10 percent a year.

The statement that Pharma put out yesterday on our plan protested that the United States currently "has a competitive marketplace that controls costs," including in its "market-based Medicare Part B program." Cost control? Market-based? I'm sorry, that doesn't sound like the Part B drug program that I run. Any others?

Something has to change in how Medicare pays for physician-administered drugs. This is widely understood across the healthcare spectrum, the political spectrum, and it has been a long time coming. The only thing standing in the way is the one special interest that has benefited from this program far out of proportion to any other actor for the last 15 years: the pharmaceutical industry.

Finally seeing this system reformed, in fact, is one of the pharmaceutical industry's ultimate nightmares. I can tell you that because it used to be my job to have pharmaceutical nightmares. (Laughter) But now we have a President who is not afraid of taking on ostensibly invincible special interests and definitely is not afraid of upsetting drug companies. That's why he was able to put forth the sweeping reform he did yesterday, which will bring a more realistic baseline price to how the Part B program pays for drugs, open it up to private sector competition, and fix perverse incentives that are driving up costs.

I want to explain briefly how this works. The payment model is based on a new report we put out on Thursday which examined the gaps between what we pay and what other countries pay for the 27 highest-cost physician-administered drugs. According to our research, right now Medicare pays 180 percent of what other wealthy countries pay for this set of costly drugs. This has a real impact not just on the Medicare program, but on beneficiaries' everyday budgets because cost-sharing in Part B can range up to 20 percent of the cost of the drug.

For some drugs, the price differences are even greater. Sometimes we're not just paying 180 percent, but 300 or even 500 percent of what other countries pay. This is a symptom of a completely broken system. Our model would fix the situation by applying a portion of these discounts, which manufacturers voluntarily give to other countries, to what Medicare pays moving forward. Over the next five years under this model, we will go from paying 180 percent of what other countries pay for these drugs to 126 percent of what they pay. As prices drop, American patients paying co-insurance will see a directly proportional drop in their out-of-pocket costs for these very expensive drugs.

Let me give you an example of how this would work. There's a drug that

some cancer patients take to fight infections which currently costs Medicare \$4,700 each time it is administered. Our wealthy peers pay an average of just \$1,100 a dose. Under our model, after the five-year phase-in, our price would be reduced to under \$1,400 a dose. Just a year into implementation the patient would already be saving \$175 each time they get the drug. By year 5, their co-insurance would be more than \$600 lower. This is a huge win for patients, especially those with expensive illnesses or conditions.

To understand the best way to implement this new system we plan to roll it out as a model covering 50 percent of the country. It's not just patients in areas covered by the model who can benefit, however. As payments within the model are reduced, the average sales price Medicare pays in the rest of the country will drop, reducing what patients outside the model will owe.

It's important to understand that this model will expand patient access through lower prices. This is a pro-patient access model. It will lower drug prices substantially for our most costly drugs without restrictions on patient access and without harming innovation. Benefits will not change. Formularies will not be imposed.

Let's think about how implausible it is that patient access would be harmed. After full implementation of the model we will still pay an average of 26 percent more for these drugs than our international wealthy competitors. To believe that this is going to meaningfully impact patient access you have to believe that drug companies will somehow find it appealing to sell a drug in Germany, Japan, and other countries at a lower price, but not to the United States at higher prices. Not only are drug companies never going to walk away from the world's largest payer for prescription drugs, they're certainly not going to walk away while they're still getting paid a quarter more than they are elsewhere.

Patients will see benefits beyond just lower drug costs because our

model will end longstanding burdens and perverse incentives created for physicians by today's buy-and-bill system. Our model will allow private vendors to take title to drugs and compete for business, letting physicians and hospitals get out of purchasing and holding drugs. Hospitals and physicians' practices should be able to focus on caring for patients, not floating capital for pricey drugs.

There are important distinctions between our model and the competitive acquisition program that was attempted in the 2000s, but failed to take off. Back then, among other restrictions, vendors were prevented from ordering drugs at will. They had to wait to order doses for individual patients, making it impossible to build a real business. On top of that, the competitive acquisition program was voluntary. How could we expect doctors to be interested in voluntarily choosing to give up making money on expensive drugs through the buy-and-bill system and choose instead the capped program?

A similar mistake was made in rolling out the Part B demonstration under the Obama administration, which Paul referenced in his opening remarks, which retained the buy-and-bill system and prevented vendors from taking title. It actually risked putting some practices underwater in the purchase of these drugs by taking revenue from doctors without touching the underlying issue of out-of-control prices and freeriding.

We believe being vendors of these drugs can be an appealing business opportunity for wholesalers, distributors, and in some cases for hospitals who have a comparative advantage in doing the negotiating themselves. At the same time, we are relieving doctors and hospitals of having to buy and hold tens of millions of dollars' worth of expensive drugs at the risk of reimbursement and we're actually expanding the pool of compensation that is available to them as providers.

All of us know that the Medicare Part B pricing system, we know it as

ASP plus 6 percent. But since the advent of budget it has actually been ASP plus 4.3 percent. Our model takes it back to 6 percent, actually expanding the pool of potential compensation for physicians and hospitals for administering these infusion drugs. This is moving in the opposite direction of the Obama administration's Part B demo where many specialists who prescribed high-cost drugs would have seen compensation cut substantially. We're seeking comment on the best ways to ensure compensation is at least steady for physicians and hospitals while ending the incentives that the 6 percent add-on creates for prescribing more expensive drugs.

We will do whatever it takes to make this new system work for doctors, patients, and hospitals. We're eager to understand the best ways to do that and the model solicits comment on it. Today's price-based compensation is a not insignificant driver of higher drug spending for patients and for the Medicare program.

However exactly we end up, we are going to keep providers whole while replacing the system with compensation that's independent of prices. This model fits into a larger effort to spark real price competition and negotiation in drug markets. A number of these physician-administered drugs are biologics and we haven't yet succeeded in building a robust market for biosimilars.

Earlier this year we did approve the first biosimilar for one of these very high-cost drugs, but there isn't nearly enough competition, in part because the current system penalizes doctors for seeking out the more affordable alternatives. Under our model that will finally change. We aim to ensure that doctors make the same money whether they are prescribing a more expensive branded biologic or its biosimilar. This gives manufacturers a meaningful new opportunity to start bringing down prices through biosimilar competition.

In doing so, this is actually going to help expand choices for patients.

We know that providers are concerned about how this could impact patient choice, but we are intent that this model not just keep patient access unfettered, but actually ensure that patients will have a choice of drugs from their provider that isn't distorted by perverse financial incentives.

I want to now address the tired talking points that we're already hearing from some quarters that this model will put a real dent in pharmaceutical R&D investment. Judging by drug companies' reaction to any changes around Part B, the implication is that any system that does not pay precisely average sales price plus 6 percent isn't capable of sustaining innovation. Indeed, yesterday the drug industry labeled me un-American and a Socialist for suggesting that this system has to change. That was interesting.

These talking points are prima facie implausible. They're also mathematically unbelievable, too. Our model will save \$17 billion in Medicare drug spending over the next 5 years. That's \$3.4 billion a year.

The pharmaceutical industry reports they spend an average of 21 percent of revenue on R&D. So at most this model could pull around \$700 million out of the entire pharmaceutical industry's annual R&D budget, which they boost is more than \$70 billion a year right now. These savings, while very substantial for American patients and American taxpayers, cannot, therefore, possibly pull out more than 1 percent of R&D.

Of course, that's assuming that companies cannot drive somewhat higher prices in Europe and Japan, which they almost certainly can do. And if they can't, they ought to get new people negotiating. And it assumes there's nowhere in their operating budgets to find a few hundred million dollars across an entire industry in new savings or efficiencies.

The final point I want to raise is why we put out the model as an Advance

Notice of Proposed Rulemaking. Brookings, of course, is one of those rare places where I could just blurt out as you know it's an ANPRM, and I'd get a lot of nodding heads. This is a highly deliberative way to go about policymaking and it actually follows two separate requests for information issued as part of the President's drug pricing blueprint and the 2019 Medicare Outpatient Payment System Rule.

On top of that, CMMI, the Center for Medicare and Medicaid Innovation, payment models are by their very nature deliberative. We believe strongly that this model is going to yield substantial benefits, but we're going to know exactly how big the benefits are because of how CMMI assesses models.

We will not just measure the results in dollars saved. One good reason to lower drug prices, among many, is that we believe it can aid medication adherence. We're planning to gather data on that and we'll also make sure to monitor patient access and quality.

But all of this deliberation has one goal: determining how we can use this model to lower drug prices while maintaining patient access and minimizing disruption for providers. The President is not turning back. We will put American patients first by reforming how Part B pays for drugs. This reference pricing model will happen.

What we're open to figuring out is how to ensure that we reshape the system in a way that benefits patients, providers, taxpayers, and everyone else who's been losing out. We will be attentive, for instance, to how the model may interact with the 340B drug discount program for hospitals and other providers. We are open to understanding how hospitals and that invest significant resources into serving vulnerable populations could be impacted by our plan. There are a lot of savings to be shared here and we have plenty of options to ensure that it's implemented in a way that minimizes disruption.

We're also open to shortening the transition period or increasing the discount beyond 30 percent, which would expand the pool of savings that could be used, and which we've closely considered already. Congress also has the power to adopt this model sooner and broader if they choose to do so.

As I mentioned earlier, rarely do these kinds of broad-based wins exist in policymaking. Here there is so much to be gained because the Part B drug program as set up for the last decade and a half wasn't really a win for anybody except the drug makers. Still, we're open to input from them, too. If there are other ways to introduce competition to this program, we want to hear them. But we waited five months for drug companies to come to the table on this particular issue with real, non-self-serving proposals, and they didn't.

We have no doubt the drug industry will be stubborn in resisting these changes. But President Trump has amply demonstrated his determination in the face of special interests. The result of this fight will be no different. We will see another victory secured by this President for American taxpayers, American doctors and hospitals, and American patients.

Thank you very much for having me here today and for coming. And I look forward to our discussion with Paul and our questions. Thank you very much.

(Applause)

MR. GINSBURG: Thank you, Mr. Secretary. The speech was very substantive and answered some of my questions, but I do have some others.

First one, a series of questions about the interaction of the International Price Index and the vendor model. I understand that vendors will not be allowed to use formularies, so they're not likely to have much leverage in negotiating prices for drugs. So in contrast to the MedPAC proposal, which would use competition to establish drug

prices, this model bases them on prices in other countries.

So first is, why bother with the vendors if they do not have the tools to negotiate drug prices, lower prices?

SECRETARY AZAR: So the reason that you have vendors is we want to remove doctors and hospitals from the business of floating inventory, having the high cost of capital of doing that, and also the perverse incentives of receiving differential reimbursement and differential profitability based on the cost and the price of the drugs that they're prescribing. A doctor's decision ought to be based on what they think the right treatment is for the patient under the circumstances, not based on the financial distortions the system builds. We hope, obviously, always that that's the case, but why build a system that has those financial incentives built into it?

In terms of vendors, we are very agnostic as to how this will work. This is why, as I mentioned, we're putting this out as an ANPRM, so that there can be input on this. We don't know which players will be the ones to do it. Right now you have wholesale distributors and specialty distributors who are the entities who actually take title and buy these infusion products and physician-administered products from the drug companies. They then sell them to doctor practices or to hospitals, oftentimes through what are called group purchasing organizations.

Those groups actually do get discounts. They get some discounts. Nothing like what we see in the middleman pharmacy benefit manager model in Part D and the commercial space, for instance, for retail products, but they do, in fact, get discounts. Volume still drives discounts.

What I suspect we will see is that distributors of one variety or another, wholesale specialty, maybe specialty pharmacies even, who take title, who are used to taking title, that they do that. They aggregate lives. The way they aggregate lives and

market power is by hospitals and physician groups, whether through GPOs or directly, contracting with them to be their supplier. It'll be a competitive system of supply. We're not requiring that you pick one supplier or one inventory manager, it's all open. So this will drive discounts.

And then the question becomes for the pharmaceutical industry, we're saying what the price is that anyone who takes title, that the distributor or wholesaler is going to get from us. And the market will drive to that or below that. And as I said, I find it fanciful to believe that when you're willing to take -- remember, this is based on the deals the pharma industry is voluntarily negotiating with Germany, France, the U.K., Japan. You're going to walk away from the world's largest market? Walk away from it because you're only getting a 26 percent premium on that? Sorry, I've been there, not going to happen.

MR. GINSBURG: Why peg the prices to those prices in other countries as opposed to having CMS determine suitable prices? In other words, isn't this outsourcing policymaking to other countries?

SECRETARY AZAR: So what we're trying to do here, we have a system right now, it's important to remember this, we have a system right now that is setting prices. The ASP is an administratively set price. It's just a really stupid way to set prices. It says, hey, manufacturer, invent whatever list price you want and we'll pay a 6 percent premium on top of that. We're trying to bring competition and market-based forces into an alternative way to pay for these drugs.

It seems to us that looking to what the pharmaceutical industry itself is willing to give by way of discounts and deals to other comparably placed wealthy countries is a good proxy for that. It's efficient. It respects competition. It doesn't have us just unilaterally setting a price based on what we think the value is. I have long been

concerned about the notion that a government bureaucrat can just arbitrarily determine the value of something in people's lives, the value to any individual cancer or rheumatoid arthritis patient of product.

This keeps Pharma -- they still are in the driver's seat. They're the ones that are negotiating these deals that become the reference price, not us. They're doing it. Their fate is in their hands. We're trying to respect as much markets and competition while dealing with a government payer system here that by its nature sets price.

MR. GINSBURG: Thank you. The President has been highly critical of other countries obtaining lower drug prices than payers in the United States. But doesn't this plan essentially copy what other countries are doing, using their leverage as purchases to lower prices?

SECRETARY AZAR: Well, it uses our leverage as a purchaser. Right now we're not using it at all. Right now we're just blindly paying a price that they give us. This will actually instead rely on what pharma companies are willing to do, and they have a choice. Pharma companies will, if countries jam them too much in other countries, they will not launch their drug in other countries. We see that, that happens. And so it'll only be the deals that they have voluntarily negotiated with other countries that will end up being a reference point here.

I'm open to any number of alternative ideas. We've asked others for ideas on ways to bring competitive pricing into the system, market-based pricing. This is fast. It's available information and it respects access and respects the pharmaceutical companies controlling their own fate. So it's the approach that we're taking here, but always open to ideas.

MR. GINSBURG: Thank you.

SECRETARY AZAR: In fact, I mean, I talked a little bit to the media

yesterday. You know, this is an idea that was discussed in congressional hearings back in the spring when we talked about drug pricing. This was an idea that Senator Cassidy raised and actually Senator Kaine from Virginia raised this with me at a hearing. And I expressed concern about doing it immediately as a single national approach and he said, well, why don't you do it as a pilot? Why don't you actually try this as a demonstration and experiment and see what will work? I'm nothing if not a good listener. (Laughter)

MR. GINSBURG: Good. Is there a risk that transactions between other countries and drug manufacturers will be pursued in a different manner, for example, with rebates that would raise list prices and thus reduce potential savings from the proposal? In other words, might drug manufacturers game this policy?

SECRETARY AZAR: So it's a good question and that's why in the Advance Notice of Proposed Rulemaking we ask about the data sources. We, of course, currently have available the net pricing information from various pricing resources to tell us what deals they're, in fact, getting. But we also are looking at requiring the drug makers, as we already do for domestic sales, for them to report to us their discounts. So that is a mechanism that I expect we will use and implement, which would be they would have to come in and actually present us, under penalty of law, with what their negotiated discounts are in the reference price countries. So I'm not at all concerned about the availability of data or their ability to game the system given that they'll have to provide that information to us.

MR. GINSBURG: Okay. Now, if this proposal can be successful for Medicare Part B, does it have potential in Medicare Part D or in the commercial insurance market?

SECRETARY AZAR: So I think it's important to remember the starting point. The starting point here is a broken pricing model. In spite of what Pharma said,

this is not a competitive market-based system when we're talking about the Medicare Part B fee-for-service program. This is us as a government payer almost just like the European countries. We are a government payer for these infusion and physician-administered products. And right now we have to set prices because there's no market-based mechanism to determine what to pay. We're just really bad at it because we take their price and pay a 6 percent markup on it. So this is a proxy using as good of competitive market-based information as we can find.

Part D, Part D works. It can work better. And we're going to be rolling out very soon the modifications that we promised in the President's blueprint to enhance the power of the Part D insurance companies to negotiate even harder against the drug companies because there are pockets of the Part D program where they're not getting the deals they can and should be able to get, as we know from the commercial space. But right now in Part D, we're getting discounts that are as good or better than what the Europeans or Japan get.

Competition is working and we're keeping the patients in the driver's seat because they have choice. We don't have a single national formulary in Part D. The patient can choose which drug plan they want. They have the ability to exit. If one plan's not meeting their needs at the right price, they can choose a different one. That competition's working.

I don't need to use a price-setting model like this in that. The system's working for seniors. The same with the outside competitive marketplace. So that's why right now we're doing this in this space because I need some way to price these drugs that's better than what we're doing.

MR. GINSBURG: Good. What about Medicaid? Is that a candidate given -- I mean, Medicaid we have "best price," which is not an ideal mechanism. Can

you envision pursuing this in Medicaid down the road?

SECRETARY AZAR: This could be a proxy in Medicaid except what I fear you will find is that we actually pay almost always vastly less than Europeans and Japan for Medicaid drugs. In fact, I think there are over 1,300 drugs for which we get them for free right now because they have 100 percent rebate under the statutory rebate formula. So I think we might end up owing money if we adopt the system in Medicaid.

MR. GINSBURG: Okay, good. Your predecessor and many congressional Republicans have objected to the mandatory demonstration approach taken in this proposal. You clearly take a different view. Can you explain why you view this tool as valuable?

SECRETARY AZAR: Well, in terms of mandatory demonstration projects and pilots, I've actually been very clear from my confirmation process on that I do not have concern about using the Center for Medicare and Medicaid Innovation authority in a mandatory way. If we are going to test propositions, we have to have valid samples. We have to do it in statistically verifiable ways that avoid sampling bias. And often mandatory is the way it will have to be done.

So I'm not at all concerned about doing that. And you'll notice that with regard to this program I think we've seen from Republican and free-market colleagues a fair degree of, if not support, at least an understanding that this is an approach that's appropriate to sue. We haven't seen people rallying around the pharma companies', you know, just knee-jerk negative reaction to this approach.

MR. GINSBURG: Yeah, thank you. Actually a follow-up to this is that, more of a philosophical question, I've been in health policy at the federal level for a long time. I remember in the 1980s with inpatient perspective payments and then the Medicare Fee Schedule. We didn't test things, we just did them. Any perspective on

how the world has changed in policymaking?

SECRETARY AZAR: Well, I think this notion of testing propositions is where we ought to be, whether it's in business or in the public sector. It's always better if we can come up with a model, test it, and verify it before generalizing it and making it broadly applicable. I think this is actually very -- especially to do it an open and transparent way as we're trying to do it here with comment, with input, I think that's just really good government as it would be really good business.

MR. GINSBURG: Thank you. Is there a possibility that some drugs might not be accessible to Medicare beneficiaries if manufacturers are unwilling to sell at a lower price?

SECRETARY AZAR: So that, of course, is the thing that Pharma came out immediately in their response, saying -- challenging patient access. I just come back to the fact that even fully implemented, we would be paying 126 percent of what they have agreed to sell their drugs for to comparably wealthy countries. And they're going to walk away from the tens of millions of American seniors that fund all of their -- basically almost all of their profit in the world? And they're going to walk away and play a game of chicken? I don't think so. But we did in our Advance Notice of Proposed Rulemaking ask for comment about what legal tools and authorities we have should that happen.

MR. GINSBURG: Good. And does HHS believe that this proposal would increase prices that other countries pay for these drugs?

SECRETARY AZAR: That'll be up to Pharma negotiating with other countries, but I would think it would create an incentive for them to draw up better deals. You know, what happens now, it is a genuine case of freeriding. I mean, this is not political sloganeering.

The pharma companies get to set their sticker price in the United States.

They can make the vast, vast majority, almost all their profitability in the United States. They then can go to these other countries and strike deals with them if it covers their marginal cost and makes them some money, and it becomes gravy. The gravy train's ending. It's over.

MR. GINSBURG: Good. Well, this would be a good time to go to the audience for some questions. I'm going to compile questions from three people and then the Secretary can answer them in any order.

Yes, sir. Peter?

SPEAKER: I can speak loudly.

SECRETARY AZAR: I'll try to repeat the question, Peter, or Paul.

SPEAKER: A little bit more on the physician side and the incentives that physicians would have. If I understand correctly, you remove the ASP plus 6 percent, but it would be applied to a drug class and not the individual drugs? Is that correct? And how much of an administrative mess do you think will occur by having to define which therapeutic area or each drug class, and fights over what's in or out of that class of drugs? Thank you. I get the mic just as I finished by question. (Laughter)

SECRETARY AZAR: And, Paul, do you want me to answer each individually or are you going to collect them together?

MR. GINSBURG: It's really up to you.

SECRETARY AZAR: I mean, I'm happy, Peter. Peter asked an excellent question which is around physician reimbursement. As I said, we're going to -- right now doctors and hospitals are receiving what's called average sale price plus 4.3 percent. So they got a cutback from the ASP plus 6 percent because of the budget sequester. We're actually increasing compensation to doctors and providers as part of this program, saying we're going to bump that up to ASP plus 6 percent for the pool of

money.

Now, we wanted to detach, though, any individual payment from being set just on the basis of price. So that's something we're asking for comment from providers and hospitals and anyone else. Peter, I hope you will help us figure this out, which is how to make that work. What we want to do is based on specialty, based on cost of administration, difficulty of administration, risk, anything else there; come up with what the appropriate fixed fee payments would be loosely based on current payments, but trying to equality that, make them neutral in terms of any discrimination between one product or one choice or the other, but have that pool be a richer one.

And we're willing to work with providers and hospitals to figure out how to -- the bottom line is we're making it clear we will make this work for doctors and hospitals. They are critical players in making this work to drive -- to have this program function and have it work. And we're going to listen to them and work with them on how to make that happen.

MR. GINSBURG: Yes, there's a woman over there. Could you wait for the mic, please? And please identify yourself.

MS. GREEN: Secretary Azar, my name is Lauren Green. I've been separated from my son since birth in the state of Georgia, where I'm flabbergasted at -- that Secretary --

MR. GINSBURG: Is this going to be about drug pricing?

MS. GREEN: -- Secretary Price was appointed. My concern is that young people without intention to retire are placed on Medicare and receive generally overall poor treatment with harmful psychotropic drugs, that the FDA should be pressured by the Health and Human Services division to continue, such as Zyprexa, Depakote, Abilify. And there is a need for an alternative plan for people under the age of retirement

so that they can be quickly rehabilitated.

MR. GINSBURG: Could you complete your question, please?

MS. GREEN: So my concern is that there should just be an overall quality of care act for prevention and that the stress should not be simply treated with simple pills. And that, like, I over the course of being placed on Medicare --

MR. GINSBURG: Okay, okay, that's enough, please. Please.

MS. GREEN: Okay.

SECRETARY AZAR: So, I mean, I'm happy to just say that if the concern is, as I think it is, around mental health especially for the young, do know that both at NIH and at the Substance Abuse Mental Health Services Agency working to try to develop both new therapies as well as nonpharmacological therapies that are available to help with mental health issues and mental crises among youth because there are special needs is vitally important.

One of the issues that has come up, been a major focus of our work at the School Safety Commission, has been this focus on mental health for kids, adolescents, high school-aged, and college-aged kids. And I think has inspired in all of us a real passion that we've got to figure out how to deliver better mental health services in schools where kids are, where they feel comfortable, and where they feel a trusting relationship. So that is something I feel passionately about, I'm going to keep driving on.

MR. GINSBURG: Thank you. Other questions? This woman on the aisle. Please wait for the mic and introduce yourself.

MS. KODJAK: Hi, Mr. Secretary. I'm Alison Kodjak with NPR. You were talking about the opposition coming from the pharmaceutical industry, but during the previous model trying to change the payment in Part B there was a huge amount of opposition from oncologists and rheumatologists. And they also whipped up a lot of

opposition among their patients. How do you -- I know you've talked about trying to keep this even for doctors, but they've already sort of expressed some concerns about this. How do you plan to answer that kind of opposition?

SECRETARY AZAR: Absolutely. So the so-called Part B demo that was proposed in the Obama administration, it simply couldn't be more different than what we're talking about here. What that did is it took reimbursement of physicians and hospitals from 106 percent of average sales price and just changed it nationwide without a demonstration or test model to 102.5 percent. It didn't change the underlying pricing. It didn't change the acquisition costs. It didn't change foreign freeriding. It simply reduced reimbursement to physicians and hospitals. They got upset. They mobilized and patient groups mobilized and it basically stopped.

That's not what we're doing here. We're changing fundamentally what the drugs will price through this foreign reference pricing model. We're adding money to actually add compensation to physicians and hospitals for their administration of the product. And I'm hopefully telegraphing as clearly as possible we want to hear from patient groups, doctors, and hospitals how we make this work for them, not how it hurts them. And so open-minded and if we call them to the table to please be partners with us in making this work.

All I hear from patient groups, hospitals, and doctors is get the price of these drugs down. Okay. We've got a plan. Now work with us on that. Make it work. We're getting the prices down. Help us make it work for you and for your patients, and I think they will.

MR. GINSBURG: Yes?

MS. KODJAK: Do you intend to completely separate compensation from the cost of the drugs? Because if you lower --

SECRETARY AZAR: Yes.

MS. KODJAK: Okay.

SECRETARY AZAR: Yes.

MR. GINSBURG: Good. This gentleman on the aisle there.

MR. RYE: Hi, this is Brian Rye from Bloomberg Intelligence. I'm curious, if you could go back in time and put on your Eli Lilly hat, if you were a -- back when you were a pharmaceutical executive, if you were presented with this proposal, how would you respond?

SECRETARY AZAR: Well, I don't own that hat anymore, so it'll be a little hard. What I would say to those in the pharmaceutical industry is change is coming. You cannot stand by or defend the status quo on drug pricing. And you can be part of the solution bringing market-based, competitive ways of compensating for drugs and lowering patient out-of-pocket costs or you can put your head in the sand and pretend change is not coming and you'll get whatever comes at it. And it may not be from people and an administration who favor supporting innovation, patient access, and patient choice.

So I encourage them to be part of the solution here I am proposing. We are driving forward with a solution that we believe is market-based, that keeps innovation and patients in the driver's seat. Be part of that. Don't just reflexively oppose any change because there will be change, and they can help choose what kind of change it is.

MR. GINSBURG: Okay. Time for one last question. The woman over there. Can you get her the mic?

MS. FIRTH: Hi, my name is Shannon Firth. I'm from MedPage Today. I just had a question about medication adherence and other quality measures. If your goal

is to reduce costs by 30 percent, do you have a target for adherence? Do you have a target for patient outcomes or any other kind of quality adherence?

SECRETARY AZAR: So I don't recall in the Advance Notice of Proposed Rulemaking if we state an actual target goal for the demonstration project on increasing medication adherence as opposed to it as a measurement that -- it is a core measurement that's part of the demonstration quality metrics. Obviously, I'm quite convinced it will increase medication adherence because we're going to be reducing our beneficiaries' out-of-pocket costs by 30 percent. That demonstrably will help with adherence.

I don't know if we have a goal in there, but we'll certainly ask for comment as part of this of is there an appropriate goal or target that we ought to set for that?

MS. FIRTH: Thank you.

MR. GINSBURG: I want to thank the Secretary for visiting Brookings and giving us a very substantive and informative address.

SECRETARY AZAR: Thank you, Paul.

MR. GINSBURG: Thank you. (Applause) I didn't mean to stop the applause, but ask that you remain in your seats until the Secretary's left the building, which will just be less than a minute, I'm sure.

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CERTIFICATE OF NOTARY PUBLIC

I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

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