BIPARTISAN POLICY CENTER

June 6, 2019

The Honorable Richard E. Neal
Chairman
House Committee on Ways and Means

The Honorable Frank Pallone, Jr.
Chairman
House Committee on Energy and Commerce

The Honorable Kevin Brady
Ranking Member
House Committee on Ways and Means

The Honorable Greg Walden
Ranking Member
House Committee on Energy and Commerce

Submitted electronically to PartDImprovements@mail.house.gov

Dear Chairman Neal, Chairman Pallone, Ranking Member Brady, and Ranking Member Walden:

On behalf of the Bipartisan Policy Center (BPC), thank you for the opportunity to provide input on potential improvements to the Medicare Part D program. BPC has long-supported cost-containment efforts and has released recommendations for reducing prescription drug costs and protecting beneficiaries from excessive out of pocket spending.[1] The House Ways and Means and Energy and Commerce Committees can play a pivotal role on this issue through significant committee jurisdictions.

As directors of BPC's health program, the below recommendations reflect our current thinking on these issues and do not necessarily represent the formal positions of BPC or its leaders. In addition, consistent with the principles of BPC's Health Project Leaders and senior BPC staff, recommendations should either be deficit neutral, or if the policies require increased federal spending, those costs should be offset to assure that changes do not add to the federal deficit.

Reform the Medicare Part D Benefit Structure

Under the current Medicare Part D benefit design, Part D and Medicare Advantage-Part D (MA-PD) plans are responsible for 75 percent of brand drug costs in the initial coverage period. Once a beneficiary reaches the coverage gap, however, plan responsibility drops to 5 percent. This creates an incentive to accelerate beneficiaries through the initial coverage period in order to limit plan financial responsibility. In the coverage gap, costs are largely shouldered by manufacturers until the catastrophic threshold has been reached. Medicare then provides individual reinsurance subsidies for 80 percent of spending. This encourages an additional push into the catastrophic phase. At the very least, the Part D structure shelters plans and manufacturers from excessive costs; at worst, it encourages the use of high cost drugs to more quickly shift responsibility to Medicare.

For these reasons, BPC supports the draft legislation to gradually restructure the Medicare Part D benefit design to increase Medicare direct subsidies and decrease reinsurance in the catastrophic phase. Improving financial alignment across the drug supply chain is a necessary step to address rising prescription drug costs. Once the transition is complete, Part D and MA-PD plans would shoulder 80 percent of costs in the catastrophic phase. This transfer of financial burden will

encourage plans to exhibit greater cost control and decrease the number of beneficiaries reaching the catastrophic phase.

Eliminate Cost-Sharing in the Catastrophic Phase

Beneficiary coinsurance covers 25 percent of brand drug list price. Once beneficiaries reach the out-of-pocket (OOP) limit and enter the catastrophic phase, cost-sharing is reduced to 5 percent. However, those with health expenditures reaching the catastrophic threshold have already incurred significant OOP costs. In 2019, beneficiaries will spend $5100 on prescription drugs before receiving catastrophic coverage.[1] BPC supports alleviating the excessive financial burden of high cost beneficiaries through the elimination of coinsurance for drugs purchased over the catastrophic threshold and creating a hard OOP cap.

Additional Recommendations to Address Part D Spending

Low-Income Subsidy

The draft legislation acknowledges the need to protect beneficiaries from an untenable degree of cost-sharing. The Medicare Payment Advisory Commission (MedPAC) has proposed additional Part D reforms, which bear consideration.[2] Because copayments for beneficiaries who qualify for the Part D low-income subsidy (LIS) are set by law, Congress could create further allowances by adjusting or eliminating copayments for certain medications. Although LIS copayments for generic and preferred multiple-source brand drugs are lower than copayments for non-preferred brand drugs, the differences are narrow relative to those experienced by other Medicare beneficiaries.

MedPAC has recommended that Congress draft legislation that provides the HHS secretary authority to modify cost-sharing to establish stronger incentives for LIS beneficiaries to select generic and low-cost brand drugs. When clinically appropriate, decreasing or eliminating copayments could encourage the use of generic drugs, preferred multisource drugs, and biosimilars. We endorse this MedPAC recommendation, which was also included in the President's FY 2020 U.S. Government budget.[3] BPC further recommends that copayments be eliminated for LIS beneficiaries utilizing generic and low-cost drugs, while copayments for non-preferred brand drugs should be slightly increased.

In addition to providing a stronger incentive for LIS beneficiaries to select lower-cost drugs, we believe that Part D plans should have stronger incentives to ensure that lower-cost brand and generic alternatives are available for LIS beneficiaries. As such, we also recommend that LIS payments to Part D plans that subsidize the deductible and cost-sharing should be limited to the amount that the government would pay for a low-cost alternative, if available, unless a higher-cost drug is prescribed as medically necessary

Reform the Drug Rebate Structure within Medicare Part D

The drug rebate structure has been under scrutiny in recent months due to a lack of transparency and unclear effect on competition and cost-control. While there are several aspects of the rebate

system that warrant review, the function of pharmacy benefit managers (PBM) has been highly publicized. The level of scrutiny on PBMs stems, in part, from their role in a thoroughly labyrinthine and opaque drug supply chain. The administration asserts that it's proposal to remove the safe-harbor protections for manufacturer rebates to PBMs, Part D plans, and Medicaid would address both beneficiary out-of-pocket costs and potential cost-inflation caused by unnecessary middlemen. This certainly merits investigation, but it is prudent to acknowledge that PBMs are the primary means of negotiation with manufacturers under the current system. In excluding rebates from the system, most actuaries (including the Administration's Office of the Actuary) project that prescription drug costs would be higher without rebates and, as such, have scored the regulation to notably increase premiums.

MedPAC has also highlighted a concern regarding the process of including rebates in the determination of when a beneficiary reaches the catastrophic phase. This practice, although not reflective of plan spending, artificially propels beneficiaries through the stages of coverage, ending in a premature entry to the catastrophic phase. As long as the current rebate structure is in place, Congress should modify rules surrounding the Part D coverage gap to prohibit Part D plans from including manufacturer rebates in the calculation of the beneficiary catastrophic OOP threshold. BPC continues to evaluate potential recommendations and supports the administration's effort to positively address transparency, competition, and beneficiary OOP costs. As additional solutions to these issues are considered, BPC cautions Congress to remain cautious of taking action with potential to increase premiums and be circumspect about eliminating rebates as a mechanism to negotiate lower rates.

Thank you for your commitment to addressing rising prescription drug costs through policies under the jurisdiction of the House W&M and E&C Committees. Thank you again for the opportunity to submit comments on legislation that can be advanced in a bipartisan and fiscally responsible manner. We look forward to continuing to work with you on this important effort.

Sincerely,

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