FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

June 6, 2019

The Honorable Richard Neal
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Frank Pallone
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Kevin Brady
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Greg Walden
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

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

Families USA, a leading national voice for health care consumers, is dedicated to the achievement of high quality, affordable health care and improved health for all. We seek to make concrete and tangible improvements to the health and health care of the nation – improvements that make a real difference in people's lives. We strive to elevate the interests of children and families in public policy to ensure that their health and well-being is foremost on the minds of policymakers.

We appreciate the opportunity to comment on the proposed Medicare Part D legislation.

The Medicare Part D program was one of the crowning achievements of Congress in 2003, providing for the first time a drug benefit program that would help America's seniors afford prescription drugs that they so desperately needed. During enactment, Families USA warned that the price of drugs was the "No. 1, 2, and 3 concern" of beneficiaries. However, we expressed concern about the clause barring direct negotiation, calling it a "lightning rod" in the law.[i]

Today, the program pays for nearly one in three prescription drugs purchased in the United States, yet the statute prohibiting the U.S. government from negotiating drug prices for beneficiaries still stands.[ii] Although plan spending per beneficiary has risen significantly in recent years, so has government reinsurance spending, which offsets what otherwise would be an increase in premiums. MedPAC's analysis of the program shows that high drug prices are the leading driver of increased per-beneficiary spending.[iii]

For a long-term solution to high and rising drug prices and program costs in Medicare Part D, Families USA recommends that your committees and Congressional leaders leverage federal purchasing power to obtain affordable and fair prices for prescription

FamiliesUSA.org
1225 New York Avenue, NW, Suite 800
Washington, DC 20005
main 202-628-3030 / fax 202-347-2417

drugs. In particular, Congress should remove the current prohibition on negotiation and create a powerful enforcement mechanism to ensure that drug companies come to the table and negotiate in good faith. See recommendations from the Coalition for Fair Drug Prices for considerations in designing a proposal for drug price negotiation in Medicare.[iv]

The Medicare Part D program does face significant challenges in its construction beyond the inability to negotiate prescription prices. Families USA applauds the Bipartisan Budget Act of 2018 for closing the coverage gap commonly known as the "donut hole" one year early for brand name drugs. This change provides consumers with a lower cost-share in Medicare Part D before they reach the catastrophic coverage phase. The final phase of closing the donut hole will level the cost share for beneficiaries' generic drug purchases, with that cost sharing set to reach 25 percent in 2020. However, closing the donut hole alone falls short of solving out-of-pocket spending issues for Medicare beneficiaries.[v]

A cap on out-of-pocket expenses would help beneficiaries – if premium increases are kept in check.

The catastrophic coverage phase of Medicare Part D currently includes a five percent beneficiary cost-share, which can result in beneficiaries paying thousands of dollars out of pocket after reaching this threshold. For select specialty drugs, beneficiaries face more than $5,000 per year, on average, in cost sharing after the catastrophic threshold alone.[vi] The number of beneficiaries who cross into the catastrophic phase has been growing year over year, which affects the number of people who face this uncapped cost sharing for high priced specialty drugs.[vii]

Capping the out-of-pocket costs in Part D to the catastrophic coverage threshold, as the draft bill proposes, would provide some peace of mind and cost savings for consumers with high drug costs. The impact on premiums would mostly be determined based on the liability plans face in the catastrophic phase. Assuming beneficiary cost caps at the level of the catastrophic phase and a maintained 80 percent government reinsurance, a leading analysis estimates premium impacts between $0.40 and $1.31 per member per month, or one to four percent. However, the current draft bill shifts much more of the catastrophic costs to plans, which deserves further scrutiny around the overall impact on premiums.

A leading factor that has kept premiums low over the past decade, despite continued price increases, is the size of the Medicare reinsurance reimbursement paid to plans. However, the share of reinsurance paid to plans continues to increase due to higher prices for drugs covered under Medicare Part D. [viii] These high prices push more enrollees into the catastrophic phase while increasing the overall Medicare spend. This is concerning because any proposal to address reinsurance alone has the potential to

mitigate government spending growth in Medicare Part D by passing an increasing cost burden to plans and ultimately to consumers.

In absence of reforms to Medicare's price negotiation power, Families USA recommends that your committees consider an out-of-pocket cost limit to assist those who use expensive medicines that is structured to limit or prevent any premium increases for all beneficiaries, so that consumers do not pay for a revenue increase for pharmaceutical manufacturers.

Comments on specific questions posed by the committees:

1. **How the Part D program is addressing the problem of high cost drugs and how the program could better address the costs of these drugs. Specifically, whether or not Congress should consider changing or eliminating the distinction between the initial coverage phase and the coverage gap discount program;**

The key difference between the initial coverage phase and the coverage gap is the discount program for brand name drugs. The discount program requires a 70 percent discount on brand drugs purchased after total spending reaches $3,820 during the initial coverage phase. Medicare Part D counts the 70 percent manufacturer discount towards a beneficiary's costs to reach the catastrophic coverage limit of $5,100.[ix]

Counting those discounts towards the catastrophic limit provides an incentive to both beneficiaries and plans to purchase brand name medicines in order to reach the catastrophic phase of coverage. Brand-name drugs are, on average, priced 18 times higher than the average generic drug price.[x] Given this price discrepancy, incentivizing more generic purchases may help decrease costs overall.

We recommend the committees consider pegging the catastrophic spending threshold at $2,200, based on the out of pocket costs for beneficiaries, regardless of type of drug purchased.

2. **What share of costs should be attributed to the beneficiary, Part D plans, and manufacturers under the current system and how this share should change if the liability were shifted for the manufacturer from the current coverage gap discount program to the catastrophic phase of the Part D benefit;**

Manufacturers currently pay the lowest share of liability within Medicare Part D.[xi] Yet, manufacturer-set prices are a leading factor for the increase in spending throughout Medicare Part D.[xii]

The current liability to manufacturers during the coverage gap creates incentives for consumers to purchase brand name medicines because they reach catastrophic coverage faster. It also provides plans with an incentive to prefer brands in the coverage gap because their share of liability is lower when purchasing brand medicines, rather than generics.

The draft text shifts liability after the catastrophic phase to plans, which would help balance incentives for plans so that they are more likely to prefer generic medications before the catastrophic limit. However, this does not change the incentive for consumers to reach the catastrophic phase faster by taking brand name medicines, since it maintains the manufacturer discount.

Families USA recommends that the committees consider giving a share of the liability in the catastrophic phase to manufacturers in the form of a discount. One way to balance the interests between manufacturers and plans would be to split the non-Medicare liability between the two. This reform, coupled with an out of pocket cap based on beneficiary spending alone, would create incentives for both plans and manufacturers to avoid pushing a beneficiary into the catastrophic coverage phase.

3. What improvements the Committees should consider with respect to low-to-moderate income Part D beneficiaries and out-of-pocket costs below the catastrophic level.

When Part D began, the Bush Administration took an approach to low-income-subsidy (LIS) enrollment that was incredibly effective. People already found eligible for Medicaid or SSI were automatically enrolled into LIS, based on data matches with state Medicaid programs and the Social Security Administration.[xiii] Enrollment has lagged for other eligible Medicare beneficiaries, unfortunately. The most recent relevant study, published in 2012, found that LIS had reached no more than 30 percent of the 10.6 million LIS-eligible Medicare beneficiaries who were not already covered by Medicaid.[xiv]

Congress should address this problem by using the same kinds of auto-enrollment strategies successfully employed at Part D's launch. Prior-year tax returns could establish eligibility for LIS, just as they determine means-tested premium levels for Medicare Parts B and D. Borrowing an approach from the Earned Income Tax Credit (EITC) program, investment income could be used as a proxy for assets, enabling a determination of LIS eligibility based on tax return data alone.[xv] By clicking a button on-line, Medicare beneficiaries could have their tax return data automatically transferred to CMS for determining LIS eligibility, leveraging the tool already used to transfer federal income-tax-data into applications for federal student aid.[xvi]

Many LIS beneficiaries pay no monthly premium and have limited cost sharing; however, availability of plans for LIS beneficiaries is dependent on the market for plan sponsors in their state of residence.[xvii]

MedPAC has recommended tweaks to LIS that could help provide savings and maintain access to important medicines for these enrollees. One of those recommendations is to reduce or eliminate cost sharing for generic drugs, preferred multisource drugs, and biosimilars. Congress should adopt this proposal to encourage the use of lower-cost alternatives, and would also provide pivotal access to LIS beneficiaries.[xviii] However, Congress should ensure access to clinically appropriate medicines through an appeals process that grants LIS beneficiaries and their prescribers an efficient way to get an exception to waive cost sharing on non-priority medicines when clinically necessary, on a case-by-case basis.

Families USA applauds the effort to rein in costs for beneficiaries

Families USA applauds the bipartisan effort to rein in high costs for Medicare Part D beneficiaries. The current structure sends far too many beneficiaries into the catastrophic phase and exposes them to an uncapped out-of-pocket burden. As high and rising prices are a leading contributor to the high out-of-pocket costs that beneficiaries face, we strongly urge action to rein in prices through negotiation on behalf of all Medicare beneficiaries. In the meantime, Congress can and should act to ensure beneficiaries are better able to afford prescriptions in Medicare Part D. The proposal outlined in the discussion draft is a good place to start in considering how to handle cost sharing throughout the Part D program, and we hope that our comment will help to inform factors to consider while reforming the program to help beneficiaries.

Thank you for the opportunity to comment on this discussion draft. We commend you for your leadership, and we look forward to working with the committees again on this important issue.

Should you wish to discuss our comments, please contact Justin Mendoza at 202-626-3030 or JMendoza@familiesusa.org.

Sincerely,

/s/

Eliot Fishman, PhD
Senior Director of Health Policy

---

[i] T.R. Oliver, P.R. Lee, H.L. Lipton. (June 2004). A Political History of Medicare and Prescription Drug Coverage. Milbank Q. 82(2): 283-354. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690175/.

[ii] Kaiser Family Foundation. (January 29, 2019). 10 Essential Facts About Medicare and Prescription Drug Spending. Retrieved April 16, 2019, from https://www.kff.org/infographic/10-essentialfacts-about-medicare-and-prescription-drug-spending/.

[iii] Medicare Payment Advisory Commission. (March 2018). Report to the Congress: Medicare Payment Policy. Retrieved June 5, 2019, from: http://www.medpac.gov/docs/default source/reports/mar18_medpac_entirereport_sec.pdf, at page 420.

[iv] Coalition for Fair Drug Prices. (May 2019). Reining in High Prescription Drug Prices: What Families Need from Congress. https://familiesusa.org/sites/default/files/product_documents/SILC_Reining-In-Rx-Drug-Prices_Whitepaper.pdf.

[v] D. Mendelson, K. Brantley, R. Kane. (May 10, 2018). More Medicare Part D Enrollees are Reaching Catastrophic Coverage. Avelere. https://avalere.com/press-releases/more-medicare-part-d-enrollees-are-reaching-catastrophic-coverage.

[vi] J. Cubanski, W. Koma, T. Neuman. (February 1, 2019). The Out-of-Pocket Cost Burden for Specialty Drugs in Medicare Part D in 2019. Kaiser Family Foundation. https://www.kff.org/report-section/the-out-of-pocket-cost-burden-for-specialty-drugs-in-medicare-part-d-in-2019-findings/.

[vii] Mendelson, Brantley, and Kane, op. cit.

[viii] Medicare Payment Advisory Commission, op. cit.

[ix] Kaiser Family Foundation. (October 12, 2018). An Overview of the Medicare Part D Prescription Drug Benefit. Retrieved June 5, 2019, from: https://www.kff.org/medicare/fact-sheet/an-overview-of-the-medicare-part-d-prescription-drug-benefit/

[x] L. Purvis and S. Schondelmeyer. (September 2018). RxPrice Watch Report: Trends in Retail Prices of Brand Name Prescription Drugs Widely Used by Older Americans: 2017 Year-End Update. AARP Policy Institute. https://www.aarp.org/content/dam/aarp/ppi/2018/09/trends-in-retail-prices-of-brand-name-prescription-drugs-year-end-update.pdf

[xi] Kaiser Family Foundation, op. cit.

[xii] Medicare Payment Advisory Commission, op. cit., at 421.

[xiii] S. Dorn. (December 2009). Applying 21st-Century Eligibility and Enrollment Methods to National Health Care Reform. The Urban Institute. https://www.urban.org/sites/default/files/publication/30761/411985-Applying-st-Century-Eligibility-and-Enrollment-Methods-to-National-Health-Care-Reform.PDF.

[xiv] J.S. Shoemaker, A.J. Davidoff, B. Stuart, I.H. Zuckerman, E. Onukwugha, and C. Powers. (2012). Eligibility and Take-up of the Medicare Part D Low-Income Subsidy. Inquiry 49: 214-230. https://journals.sagepub.com/doi/pdf/10.5034/inquiryjrnl_49.03.04.

[xv] S. Dorn and B. Shang. (February 2012). Spurring Enrollment in Medicare Savings Programs Through a Substitute for the Asset Test Focused on Investment Income. The Care Span. Health Affairs 31 (2): 367-375. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2011.0443.

[xvi] The IRS Data Retrievel Tool (IRS DRT) Electronically Transfers Your Federal Tax Return Information You're your FAFSA Form. U.S. Department of Education Office of Federal Student Aid. Retrieved June 6, 2019: https://studentaid.ed.gov/sa/resources/irs-drt-text.

[xvii] Kaiser Family Foundation, op. cit.

[xviii] Medicare Payment Advisory Commission, op. cit., at 404.