

July 24, 2019

The Honorable Chuck Grassley
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Richard Neal
Chairman
Committee on Ways & Means
United States House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Greg Walden
Ranking Member
Committee on Ways & Means
United States House of Representatives
1139 Longworth House Office Building
Washington, DC 20515

Dear Chairman Grassley, Ranking Member Wyden, Chairman Neal, and Ranking Member Walden,

The undersigned organizations are writing to express our appreciation for your leadership on efforts to limit the out-of-pocket (OOP) costs for prescription drugs for Medicare Part D beneficiaries.

On July 16th the Alliance for Aging Research convened a stakeholder roundtable to discuss the challenges that Part D beneficiaries face, and to identify potential policy solutions. The outcome of this community meeting was the development of a broad set of principles that the participating stakeholders believe should be incorporated into Part D legislative proposals. We have included those principles below and we respectfully request that you consider them as you work to craft legislation to help reduce the OOP Part D burden for Medicare beneficiaries.

An Affordability Crisis

First and foremost, it should be acknowledged that Part D is working well for the majority of the 47 million Medicare beneficiaries enrolled in the program in 2019.¹ A recent survey by Morning Consult and commissioned by the Alliance for Aging Research, found that 92 percent of Medicare beneficiaries are either “very satisfied” or “somewhat satisfied” with their current insurance coverage². Survey work by Morning Consult found that 8 in 10 beneficiaries believe their drug plan is a “good value.”³

Despite the decade of success for the Part D program, of concern is the significant number of older adults facing extraordinarily high OOP costs for their prescription medications. Avalere Health estimated that in 2016 an estimated 800,000 Medicare beneficiaries were burdened with more than \$5,000 in true-out-of-

¹ 2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2019.pdf>.

² “New Survey Shows Older Adults Are Willing to Pay More in Monthly Medicare Premiums to Ensure a Cap on Out-Of-Pocket Prescription Drug Costs.” Alliance for Aging Research, 16 July 2019, www.agingresearch.org/press-release/new-survey-shows-older-adults-are-willing-to-pay-more-in-monthly-medicare-premiums/.

³ Medicare Today. 2018 Senior satisfaction survey. <http://medicaretoday.org/wp-content/uploads/2016/07/8.13.18-Senior-Satisfaction-Survey-Fact-Sheet-NL-002.pdf>. Published August 2018.

pocket (TrOOP) costs in Medicare Part D—which includes OOP expenses, drug manufacturer payments to discount programs, and charitable assistance. Most troubling though, is that the same analysis found the number of beneficiaries who triggered catastrophic coverage grew by more than 50 percent from 2013 to 2016⁴. While it is only a subset of patients incurring these very high prescription drug costs in Part D, it is important to understand that, in any given year, any individual could become seriously ill and incur these high costs.

Currently, there is no ceiling on potential OOP costs for Part D beneficiaries. Those that reach the catastrophic phase of the Part D benefit incur 5% coinsurance for each prescription, which can be substantial. Additionally, it should be noted that, unless changed by legislation, Calendar Year (CY) 2020 enrollees will experience an increase of \$1,250 in the annual TrOOP threshold—from \$5,100 in 2019 to \$6,350 in 2020, because the reduced annual growth rate in the TrOOP threshold as implemented under the Affordable Care Act will end.⁵

Out-of-pocket costs for prescription drugs can be so high that many patients forego their prescribed medication. The Alliance for Aging Research survey found that one in five Medicare beneficiaries report having stopped taking a prescription medication because of the cost. One in four adults with a chronic condition also reported having stopped a prescription medication due to cost concerns⁶.

Because of the direct impact of OOP costs on access to needed treatments, we urge Congress to prioritize efforts that will reduce OOP spending for the individuals served by the Part D program.

Principles for Affordability Reform in Part D

Medicare Part D should have a cap on OOP costs

We believe that all enrollees in Medicare Part D should have a cap on OOP drug expenses. Placing a cap on patient OOP spending will help to ensure beneficiaries can access the drugs they were prescribed and live healthy, productive lives. As you know, there are a few ways to limit OOP spending—and they are not mutually exclusive:

- An annual cap;
- A monthly cap; and
- A per-prescription cap as implemented in California.

While there was not a consensus during the stakeholder meeting regarding the preferred type of cap, several stakeholders noted that a monthly cap would provide the greatest relief to patient affordability

⁴ Mendelson, Dan, et al. “More Medicare Part D Enrollees Are Reaching Catastrophic Coverage.” Avalere Health, 10 Oct. 2018, www.avalere.com/press-releases/more-medicare-part-d-enrollees-are-reaching-catastrophic-coverage.

⁵ CMS. “Announcement of Calendar Year (CY) 2020 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter.” April 2019:64.

⁶ “New Survey Shows Older Adults Are Willing to Pay More in Monthly Medicare Premiums to Ensure a Cap on Out-Of-Pocket Prescription Drug Costs.” Alliance for Aging Research, 16 July 2019, www.agingresearch.org/press-release/new-survey-shows-older-adults-are-willing-to-pay-more-in-monthly-medicare-premiums/.

challenges. Additionally, the Alliance for Aging Research survey found that 46 percent of Medicare beneficiaries support a monthly cap, versus 24 percent who support an annual cap⁷.

For caps to not be exceedingly expensive, health plans will likely need to be given more tools to control costs after a beneficiary has reached the catastrophic phase. Policymakers need to be thoughtful about the balance of controlling costs in the catastrophic phase, while ensuring patients will be able to maintain access to the medications they need. The goal of an OOP cap is to facilitate access to treatment, not impede it.

The economic realities of the average beneficiary need to be realized

Half of Medicare beneficiaries are living on an annual per capita income of less than \$26,200⁸. As the Committee considers how to pay for a cap, we ask that you seek to limit the potential for significant premium increases. Older adults and others with Medicare can face substantial OOP healthcare costs in a given year, including premiums, deductibles, cost-sharing for covered-services, and the cost of noncovered-services. The Alliance for Aging Research survey found that older adults were willing to pay slightly more in premiums (the survey used a hypothetical increase of between \$4 and \$8 per month) in exchange for an OOP cap, acknowledging the likely trade-offs to achieve these goals.

Congress should explore how to “smooth” expenses for beneficiaries with high upfront drug costs over the course of a benefit year

As it currently stands, beneficiaries taking high-cost medications bear a significant financial cost at the beginning of their plan year, i.e. January and February. This is because specialty medications can “burn through” the enrollee’s deductible, as well as the Initial Coverage Phase very quickly. According to the Medicare Payment Advisory Commission, high-cost enrollees will spend an average \$2,140 on Part D drugs per month⁹. For many older adults, this means they must pay a significant portion of their fixed incomes over a short duration of time.

We encourage the Committee to consider policy solutions to assist non-LIS beneficiaries who are having to deal with concentrated medication costs in the earliest months of the year. For this to work, however, several other complex issues need to be considered, including addressing safe harbor laws, determining liability, and finding ways to address high-cost, short-duration prescriptions. Further, we encourage the Committee to consider looking to potential solutions from the private sector including well-regulated flexible payment plans for beneficiaries who need more time to pay their OOP over the course of the year.

The entire healthcare costs of older adults need to be considered

The total cost of care for a patient needs to be considered, outside of just their Part D costs. It needs to be understood that even if Part D is fixed, too many beneficiaries are still having difficulty affording their physician and clinic visits, other healthcare services, diagnostic testing, etc. Access to care is impacted by the totality of premiums, copayments, coinsurance, and deductibles—across the care continuum. If we

⁷ “New Survey Shows Older Adults Are Willing to Pay More in Monthly Medicare Premiums to Ensure a Cap on Out-Of-Pocket Prescription Drug Costs.” Alliance for Aging Research, 16 July 2019, www.agingresearch.org/press-release/new-survey-shows-older-adults-are-willing-to-pay-more-in-monthly-medicare-premiums/.

⁸ Jacobson, Gretchen, et al. “Income and Assets of Medicare Beneficiaries, 2016-2035.” The Henry J. Kaiser Family Foundation, 21 Apr. 2017, www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2016-2035/.

⁹ “Payment Policy for Prescription Drugs under Medicare Part B and Part D.” 2019.

only address access to prescription therapies, we will be fixing just one of many problems in the access to care issue.

Incentives need to be realigned

Finally, we encourage you to reconsider the structure of the Part D benefit—the landscape of which has dramatically changed since it was signed into law—in order to realign financial incentives that may currently prefer the higher cost product.

Conclusion

On behalf of our organizations—representing healthcare providers, pharmacies, pharmaceutical and biotechnology companies, payers, charitable patient assistance programs, pharmacy benefit managers, and patients and family caregivers—thank you for your attention to our recommendations. We stand ready to work with you to ensure access to care for Medicare Part D beneficiaries. Please feel free to contact Sue Peschin, president and CEO of the Alliance for Aging Research, with any questions—202-293-2856 or speschin@agingresearch.org.

Sincerely,

Alliance for Aging Research
Association of Community Cancer Centers
Biotechnology Innovation Organization
Black Women’s Health Imperative
CancerCare
Caregiver Action Network
Epilepsy Foundation
National Health Council
National Hispanic Medical Association
National Medical Association
National Patient Advocate Foundation
Patient Access Network (PAN) Foundation
The AIDS Institute

cc: U.S. Senate Majority Leader Mitch McConnell, U.S. Senate Minority Leader Chuck Schumer, U.S. House Speaker Nancy Pelosi, and U.S. House Minority Leader Kevin McCarthy