



National Health Council

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June 6, 2019

The Honorable Frank Pallone
Chairman
House Committee on Energy and Commerce

The Honorable Richard Neal
Chairman
House Committee on Ways and Means

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

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

Dear Representatives Pallone, Neal, Walden, and Brady:

The National Health Council (NHC) appreciates this opportunity to provide feedback on the draft Medicare Part D reform legislation that the Ways & Means and Energy & Commerce Committees jointly released on May 23.

Founded in 1920, the NHC is the only organization that brings together all segments of the health community to provide a united voice for the more than 160 million people with chronic diseases and disabilities and their family caregivers. Made up of more than 125 diverse national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient advocacy organizations, which control its governance and policy-making process. Other members include health-related associations and nonprofit organizations including the provider, research and family caregiver communities, and businesses representing biopharmaceutical, device, diagnostic, generic, and payer organizations.

The NHC is committed to ensuring patients have access to affordable, high-value medications. We share your concern that many Medicare beneficiaries currently struggle to afford their medications due to high out-of-pocket (OOP) costs, even when they are enrolled in a Part D plan. Some enrollees in Part D plans face many thousands of dollars in OOP costs for medications every year in addition to the OOP costs they may have for other health care services. Under existing law, Medicare Part D does not cap OOP costs for beneficiaries who are not eligible for the low-income

subsidy (LIS) program.¹ When non-subsidized Part D enrollees reach the catastrophic threshold, they continue to incur OOP expenses, in the form of five percent coinsurance, for the rest of the benefit year.

For these reasons, the NHC has long supported a cap on OOP costs in Medicare Part D. We are pleased that this issue has attracted increased attention in recent years, and we have documented our support for Congressional action to address this matter as recently as this past April.² We also support the Committees' proposal to realign incentives related to spending in the catastrophic phase.

Since the launch of Part D plans in 2006, many factors have shifted in the policy and drug landscapes. The Part D program benefit design included an actual gap in coverage where patients were required to pay the full cost of their medications to reach the catastrophic phase of the benefit. Today, that gap is nearly closed. In 2006, the range of medications available was far less broad and deep than today. Today, there are therapies available that better manage, and sometimes even cure, the health conditions beneficiaries face. These changes are indeed improvements for patients in Medicare. But, the policy of Part D has not kept pace with the advancing science of medications and many Medicare beneficiaries are paying the price for the lack of policy advancement.

The closure of the coverage gap has succeeded in helping more people with Medicare access their needed medications. At the same time, the coverage gap closure and changes introduced by the Bipartisan Budget Act of 2018 have resulted in more beneficiaries reaching the catastrophic threshold. In 2016, one million non-LIS Medicare beneficiaries reached the catastrophic phase, a number that has grown significantly in recent years.³ Further, other factors such as increasing manufacturer discounts and rising average-negotiated prices in Part D have also accelerated the progression of patients through the Part D benefit design into catastrophic coverage. These increased average-negotiated prices also mean that the total amount of spending that occurs in the catastrophic phase of the benefit is growing. According to MedPAC, "Aggregate spending for high-cost enrollees (i.e., including catastrophic and non-catastrophic spending) grew from about 40 percent of Part D spending before 2011, to 44 percent in 2011, to 58 percent in 2016," which "reflects an annual 10 percent increase in per capita spending for high-cost enrollees."² And, since the federal government is responsible for 80 percent of spending in the catastrophic phase, these trends impact the Medicare program as well as the OOP costs of Medicare patients. Thus, the NHC also is supportive of proposals to shift the share of costs in the catastrophic phase to realign incentives in the program.

This bill, as drafted, represents a good first step toward lowering Medicare Part D enrollees' OOP costs. However, we encourage the Committees to consider additional protections for beneficiaries into the final versions by:

- Distributing beneficiary cost-sharing throughout the year;

¹ 71% of Part D enrollees do not receive low-income subsidies. Cubanski, Juliette, Anthony Damico, and Tricia Neuman. "Medicare Part D in 2018: The Latest on Enrollment, Premiums, and Cost Sharing." *Kaiser Family Foundation*. May 17, 2018. Viewed May 28, 2019. <https://www.kff.org/medicare/issue-brief/medicare-part-d-in-2018-the-latest-on-enrollment-premiums-and-cost-sharing/>.

² NHC Comments on Anti-Kickback-Statute Safe Harbor RFI. https://www.nationalhealthcouncil.org/sites/default/files/NHC_Comments_Rebate_Safe_Harbor.pdf

³ MedPAC. Report to Congress: Medicare Payment Policy. March 2019. Available at http://www.medpac.gov/docs/default-source/reports/mar19_medpac_ch14_sec.pdf?sfvrsn=0.

- Protecting beneficiaries from unintended consequences through oversight and transparency; and
- Considering additional solutions to make OOP costs more affordable for non-subsidized beneficiaries.

Distribute annual OOP spending.

The NHC believes that an OOP cap in Part D can help make drugs more affordable for the Medicare population. However, to achieve the best protections for beneficiaries, we encourage the Committees to restructure the proposed cap slightly. The draft bill establishes an OOP cap based on the present catastrophic threshold. This structure requires the enrollees who spend the most on drugs to bear the brunt of their expenses during the first few months of the year. According to the Medicare Payment Advisory Commission, high-cost enrollees, on average, spend \$2,140 on Part D drugs per month.⁴ This means that before the month of April is over, those enrollees have already reached the catastrophic phase.

If the OOP maximum is based on the current catastrophic limit, individuals who reach that limit will continue to face prohibitive expenses that are concentrated within the first few months of the year. The NHC encourages the Committees to consider options that allow OOP costs to be distributed more evenly throughout the benefit year. The NHC also asks the Committees to consider working with stakeholders, including patient advocates, to help the Committees align on a mechanism that would best benefit patients. We and our members stand ready to assist the Committees in this effort.

Protect beneficiaries from unintended consequences through oversight and transparency.

NHC is committed to ensuring that changes to the Part D benefit structure do not discriminate against vulnerable populations, particularly people with chronic and complex conditions. While we are fully supportive of modifications to the benefit structure to include an OOP maximum, this transformative change to the Part D program – in addition to other changes being pursued by the administration - could upend incentives and, thus, requires an additional layer of oversight to ensure patients are protected. That includes ensuring that bad actors within the system do not act in ways that harm enrollees. We ask the Committees to add language that requires CMS to reinforce proper oversight and enforcement protocols over plan formularies and utilization management tools. We also ask the Committees to require CMS to improve information transparency on Plan Finder to ensure patients are aware of adjustments to their benefit to help them choose the most appropriate plan. Adding these layers of protection for beneficiaries could prevent them from paying more than necessary at the pharmacy counter.

Consider additional solutions that make the OOP cap more affordable.

As stated above, the NHC strongly supports a cap on OOP costs for non-subsidized Medicare Part D enrollees. A cap would offer considerable protection for those patients who have high drug needs. At the same time, there are many individuals and families whose income and/or assets are not quite limited enough to qualify for Part D subsidies today. To qualify for full subsidies that cap OOP costs, a family of two cannot have income that exceeds about \$23,000 a year in 2019. And, this family would face the same cap on OOP costs—\$5,100 per person in


⁴ MedPAC. Payment policy for prescription drugs under Medicare Part B and Part D. Available at http://www.medpac.gov/docs/default-source/congressional-testimony/04_30_2019_medpac_drug_testimony_for_eandc.pdf?sfvrsn=0.

2019⁵—as a family at the highest end of the income scale. In this example, if both family members have high needs, they could face paying a large portion of their annual income on OOP costs on top of their Part D plan premiums and all their other expenses. Non-LIS beneficiaries whose income and assets are slightly above the LIS eligibility pay a significantly higher percentage of their total income towards OOP costs relative to a beneficiary with a higher income. Thus, we ask the Committees to consider options to implement an OOP cap that offers more meaningful protections to Medicare beneficiaries whose income and/or assets do not allow them to qualify for full subsidies. This can be achieved, either by raising the threshold for LIS eligibility, offering a lower OOP cap for those just about the threshold, or a combination of both. This adjustment to the Committees' proposed bill would serve as an additional layer of protection for many of the most vulnerable patients.

If you or your staff would like to discuss these issues further, please contact Eric Gascho, our Vice President of Policy and Government Affairs, at (202) 973-0545 or egascho@nhcouncil.org. Thank you for the opportunity to provide feedback on this draft legislation.

Sincerely,

Sincerely,



Marc Boutin, JD
Chief Executive Officer
National Health Council

⁵ \$5,100 includes all sources of True Out-of-Pocket Costs (TrOOP), including beneficiary OOP spending and manufacturer contributions paid during the coverage gap.