



National Health Council

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The Honorable Charles Grassley

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Senate Committee on Finance

221 Dirksen Senate Office Building

Washington, DC 20510

The Honorable Ron Wyden

Ranking Member

Senate Committee on Finance

135 Hart Senate Office Building

Washington, DC 20510

Dear Chairman Grassley and Ranking Member Wyden:

As the Senate Finance Committee is crafting legislation related to prescription drug and other health care costs, the National Health Council (NHC) writes this letter in support of a cap on out-of-pocket (OOP) costs for Medicare Part D beneficiaries as one way to reduce costs for our nation's seniors.

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 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 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-

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/>.

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 this reason, the NHC has long supported a cap on OOP costs in Medicare Part D.² We are pleased that this issue has attracted increased attention in recent years, and we recently supported draft legislation by the House Committees on Energy and Commerce and Ways and Means to realign incentives related to spending in the catastrophic phase with some suggested modifications which are also outlined in this letter.³

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. Additionally, the range of medications available in 2006 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.⁴ 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.”⁵ 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.

A hard cap on OOP costs and realigned incentives represent a good first step toward lowering Medicare Part D enrollees’ OOP expenses. However, we encourage the Committee to consider additional protections for beneficiaries into the final versions by:

- Distributing beneficiary cost-sharing throughout the year;
- Protecting beneficiaries from unintended consequences through oversight and transparency; and
- Considering additional solutions to make OOP costs more affordable for non-subsidized beneficiaries.

² NHC Comments on Anti-Kickback-Statute Safe Harbor RFI.

https://www.nationalhealthcouncil.org/sites/default/files/NHC_Comments_Rebate_Safe_Harbor.pdf

³ NHC Letter to Energy and Commerce and Ways and Means Committee’s on Draft Legislation for a Part D Cap.

http://www.nationalhealthcouncil.org/sites/default/files/NHC_Comments_House_Part_D_Reform_Proposal.pdf

⁴ 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.

⁵ Ibid.

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 Committee to structure a cap that spreads OOP costs throughout a calendar year. As we have seen in other markets, annual caps require 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.⁶ 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, many 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 Committee to consider options that allow OOP costs to be distributed more evenly throughout the benefit year. The NHC also asks the Committee to consider working with stakeholders, including patient advocates, to help develop a mechanism that would best benefit patients. We and our members stand ready to assist the Committee in this effort.

Protect beneficiaries from unintended consequences through oversight and transparency.

The 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 Congress and 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 Committee to add language that requires CMS to reinforce proper oversight and enforcement protocols over plan formularies and utilization management tools. We also ask the Committee 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 2019⁷—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

⁶ 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.

⁷ \$5,100 includes all sources of True Out-of-Pocket Costs (TrOOP), including beneficiary OOP spending and manufacturer contributions paid during the coverage gap.

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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 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,



Marc Boutin, JD

Chief Executive Officer

National Health Council