

June 6, 2019

The Honorable Richard E. Neal
Chairman
Committee on Ways and Means
United States House of Representatives
Washington, D.C. 20515

The Honorable Frank Pallone, Jr.
Chairman
Committee on Energy and Commerce
United States House of Representatives
Washington, D.C. 20515

The Honorable Kevin Brady
Ranking Member
Committee on Ways and Means
United States House of Representatives
Washington, D.C. 20515

The Honorable Greg Walden
Ranking Member
Committee on Energy and Commerce
United States House of Representatives
Washington, D.C. 20515

Re: AGS Comments on Draft Medicare Part D Legislation

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

The American Geriatrics Society (“AGS”) appreciates the opportunity to provide input on the House Ways and Means and Energy and Commerce Committee’s bipartisan draft legislation on Medicare Part D improvements. Founded in 1942, the AGS is a nationwide, not-for-profit society of geriatrics healthcare professionals dedicated to improving the health, independence, and quality of life of older people. Our nearly 6,000 members include geriatricians, geriatric nurses, social workers, family practitioners, physician assistants, pharmacists, and internists who are pioneers in advanced-illness care for older individuals, with a focus on championing interprofessional teams, eliciting personal care goals, and treating older people as whole persons. The Society provides leadership to healthcare professionals, policymakers, and the public by implementing and advocating for programs in clinical care, research, professional and public education, and public policy that can support us all as we age.

We appreciate the Committees’ focus on reducing the cost of prescription drugs. Below please find our comments on the proposed legislation and responses to the questions put forth by the Committees.

COMMENTS ON PROPOSED LEGISLATION

The proposed legislation seems problematic as shifting the costs of catastrophic care to health plans would likely raise plan costs significantly, which would then get passed along to consumers in the form of higher premiums, co-pays, and deductibles. Those to be hurt by the legislation are individuals with lower incomes who don’t qualify for the “full extra help,” and more medically complex older adults who often rely on multiple medications. Substantial increases in plan costs may also prompt stricter prior authorization requirements and step therapy requirements and limits on patients’ formulary options. Stricter prior authorization requirements, for example, has significant potential to harm patients who

may be unable to get medications they need on a timely basis, resulting in patients suffering untreated symptoms while they wait and/or having to be admitted to the hospital for care.

The AGS believes the principal possible advantage to the approach proposed in the bill would be that plans would have greater incentives to negotiate price concessions from manufacturers of highly expensive drugs. However, giving the Centers for Medicare and Medicaid Services (“CMS”) direct authority to negotiate drug prices would be a far more effective strategy to lower drug costs for all beneficiaries.

COMMENTS ON QUESTIONS

- 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 AGS believes that one way the Part D program could better address the problem of high cost drugs would be if **CMS based the cost-sharing formula not on the “list price” created by the plans and manufacturers but on net prices after rebates.** One option could explore having the Pharmacy Benefit Manager (“PBM”) pricing model based on a fee for their services (or even based on value) versus a percentage of the prescription drug cost (which also provides an incentive to place expensive medicines on formularies).

In addition, in our experience, plans try to keep premiums low to attract enrollees but are increasingly moving to a co-insurance (%) vs. a flat co-pay during the initial coverage phase as a way to shift drug costs to consumers. Thus, under the current Medicare Part D framework, enrollees with more costly illnesses have a perverse incentive to use more expensive brand drugs so they can quickly reach the 5% catastrophic level, at which Medicare pays 80% of the drug cost. Unfortunately that increases Medicare’s liability for more expensive medications in the catastrophic phase, which disproportionately drives up Part D costs.

There is a distinction between the initial coverage phase (when enrollees often pay co-payments but are moving to more co-insurance) and the coverage gap discount (where enrollees always pay a co-insurance). For health literacy reasons, **we believe that it would be ideal if coverage were the same for both phases,** which could mean that there would be an even bigger shift to co-insurance in the initial phase. **Thus, this shift would be combined with other ways to lower medication costs (using net prices mentioned above)** so that it is a win-win for the consumer and Medicare and is fair to the plans. Those with more limited incomes will need more protection if there is more move to co-insurance.

- 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; and**

The AGS believes that shifting the liability to the manufacturer during the catastrophic phase makes good sense as it might help keep prices below the catastrophic level. However, this would mean that Medicare would pick up much more costs during the “coverage gap” and we are not sure how the math would pan out. According to an August 2018 report from the Kaiser Family Foundation, five times as many beneficiaries enter the coverage gap than those who reach the catastrophic level.¹

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.

First and foremost, we believe that **CMS should adjust the income guidelines and the assets test for full and partial low-income subsidy (“LIS”).** It is very low and punishes individuals who have saved a small nest egg. Even a single beneficiary whose income is at or below 100% the federal poverty level (“FPL”) does not qualify for LIS if he or she has cash assets above \$14,390. The cost-sharing required of those with LIS is minimal (especially the full LIS = \$1.25 to \$8.50/Rx for a 30-day supply) which provides little incentive for enrollees to try less expensive medications and exacerbates incentives for manufacturers to keep “list prices” high. Those with partial LIS pay 15% of the cost after a small deductible that is based on the list price, not net price (post rebates) during the initial coverage phase. They also qualify for a sliding-fee scale to lower their Part D premiums. If rebates were shared with the consumer at the “point of sale,” prices at the pharmacy counter might be lower but premiums would likely rise, since most plans use rebates to make premiums more affordable.

We would also like to note that 15% co-insurance for beneficiaries with partial LIS can be unaffordable for those with expensive medications. We **urge the Committees to explore imposing a cap on the total amount for one medication co-pay/co-insurance for beneficiaries with partial LIS.**

We also believe that pharmacies should be in or out-of-network. Forcing beneficiaries to “chase” for the “preferred” pharmacy is extremely challenging for older adults, especially those with serious medical conditions and creates great potential for medication errors (e.g., resulting from changing plans and transferring prescriptions every year). While preferred pharmacies can save money, they may also be disruptive for older patients who have to establish a relationship with a new pharmacy/pharmacist, who can be an essential part of a senior’s health care team, each time the preferred network is changed.

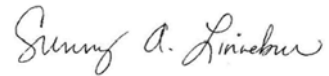
The **Committee should also ensure that low-to-moderate income patients know they are eligible for extra help through Social Security.**

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¹<https://www.kff.org/medicare/issue-brief/closing-the-medicare-part-d-coverage-gap-trends-recent-changes-and-whats-ahead/>

Thank you for the opportunity to submit these comments. We would be pleased to answer any questions you may have. Please contact Alanna Goldstein at agoldstein@americangeriatrics.org.

Sincerely,



Sunny Linnebur, PharmD, BCGP, BCPS, FCCP, FASC
President



Nancy E. Lundebjerg, MPA
Chief Executive Officer