

June 6, 2019

The Honorable Richard Neal  
Chairman  
Ways & Means Committee  
U.S. House of Representatives  
1102 Longworth House Office Building  
Washington, D.C. 20515

The Honorable Frank Pallone, Jr.,  
Chairman  
Energy and Commerce Committee  
U.S. House of Representatives  
2107 Rayburn House Office Building  
Washington, D.C. 20515

The Honorable Kevin Brady  
Ranking Member  
Ways & Means Committee  
1011 Longworth House Office Building  
Washington, D.C. 20515

The Honorable Greg Walden  
Ranking Member  
Energy and Commerce Committee  
2185 Rayburn House Office Building  
Washington, D.C. 20515

**RE: Draft Medicare Part D Legislation**

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

The American College of Rheumatology (ACR), representing over 9,500 rheumatologists and rheumatology interprofessional team members, appreciates the opportunity to provide feedback on the draft legislation creating an out-of-pocket maximum on prescription drug costs for Medicare beneficiaries in Part D based on the current catastrophic threshold. Rheumatologists provide care for millions of Americans and are the experts in diagnosing, managing and treating arthritis and rheumatic diseases. These life-long, chronic conditions include rheumatoid arthritis, systemic lupus erythematosus, and vasculitis, among many others. Rheumatic diseases and arthritis are the leading cause of disability in the United States. Reducing high drug costs and improving patients' access to treatments are top priorities for the ACR.

Early and appropriate treatment by a rheumatologist is vital to controlling disease activity, preventing and slowing progression, improving patient outcomes, and reducing the need for costly downstream procedures and care. Rheumatologists practice in every state, the District of Columbia, and Puerto Rico, and in all communities, both urban and rural. They provide critical care for people with diseases that can be crippling, life-changing, and life-threatening.

The ACR is pleased to see Congress focus on the affordability of Part D treatments. We are supportive of policies that will make life-changing treatments more readily accessible for rheumatology patients. We agree that higher beneficiary cost-sharing is a barrier to care – particularly in Medicare Part D – and we support the development of legislation that would reduce beneficiary out-of-pocket costs in the Medicare program. We are also concerned about the possibility of measures that may result in an increase in premiums for Part D

coverage, or formulary changes that might further reduce the accessibility of these treatments.

The ACR believes that safe and effective treatments should be accessible to all patients at the lowest possible cost, and that this should be a fundamental basis for any drug-pricing policy. We support policies rooted in scientific evidence that support shared decision-making between patients and their health care team and that decrease barriers to patients accessing treatment. We respectfully request that the following patient protections and proposed solutions be carefully considered.

The financial burden on patients can lead to decreased health care use that has included prescription abandonment, lack of initiation of recommended medications, and lack of persistence with medications. Therefore, any legislation reducing or capping the out-of-pocket cost to patients under Medicare Part D should protect against possible increases in premiums that may be implemented in response to the payers' responsibility rising from 15% of the cost of Part D treatments to 80% which may leave patients with the same or higher out-of-pocket costs.

We support the concept of an out-of-pocket maximum for patients, and reducing the 5% payment in the catastrophic phase down to zero. However, such legislation must prohibit formulary changes like new step therapy protocols or forced medication switches made by parties other than the prescribing physician, which might be implemented in reaction to such a cap leaving patients with more barriers in accessing these treatments than the cost prohibitions which the legislation addresses.

The ACR has multiple recommendations with regard to how the Part D program could better address the problem of the high cost of drugs. We strongly oppose the excessive patient cost sharing that results from specialty cost tiering practices utilized by insurance carriers. Coinsurance requirements for non-preferred drugs placed on specialty tiers can result in excessive patient financial burden, which may lead the patient to forgo appropriate treatment altogether. We support limiting cost sharing for specialty drugs.

Congress should also take steps to rein in the rampant overuse of prior authorization in the Part D program, in particular for treatments that are routinely approved. We support implementation of the option of electronic prior authorization, along with a more fluid EHR process, which will reduce delays in patients receiving necessary treatments and reduce the time their doctors have to spend away from patients handling prior authorization processes and appeals.

Additionally, drug price information should be provided to patients through explanation of benefits (EOBs). Beneficiaries should have access to this helpful information and any ways to lower their out-of-pocket costs. It would most helpful for prescribers to know patients' out of pocket costs while prescribing a medication in the electronic health record in order to further assist patients at the point of care. We suggest that Part D plans and benefits managers be required to work with EHR vendors toward this goal, while not placing additional burden on patients and their physicians.

However, stable patients should not be forced to switch to another medication for the sake of cost control. Switching treatments of stable patients needlessly disrupts continuity of care and puts patients at significant risk for loss of disease control and potentially life-threatening complications. Plans should be monitored closely for non-medical switching and should be required to provide transparency about any utilization management requirements. The requirements should be directly disclosed in their explanation of coverage during the open enrollment process through plain, clear language about what these requirements mean for patients and what their options are. Importantly, Part D benefits should not limit, incentivize, or otherwise steer doctors or patients away from the medical therapy which the treating rheumatologist judges to be the most efficacious choice. Allowing the most appropriate and efficacious therapy as judged by the treating physician can also result in long-term cost savings.

The American College of Rheumatology appreciates the work the Ways & Means and Energy and Commerce committees do and the opportunity to respond to this draft of proposed legislation. We look forward to serving as a resource to you and to working with the committee as you consider ways to reduce high out-of-pocket costs and increase patient access to the treatments their providers prescribe. Please contact Lennie S. Shewmaker, J.D., Senior Manager of Federal Affairs, at [LShewmaker@rheumatology.org](mailto:LShewmaker@rheumatology.org) or (404) 365-1375 if you have questions or if we can be of assistance.

Sincerely,

A handwritten signature in black ink, appearing to read "AWorthing", with a stylized flourish at the end.

Angus B. Worthing, MD, FACP, FACR  
Chair, Government Affairs Committee  
American College of Rheumatology