



**BlueCross BlueShield
Association**

An Association of Independent
Blue Cross and Blue Shield Plans

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June 6, 2019

The Honorable Chairman Richard E. Neal
The Honorable Chairman Frank Pallone, Jr.
Ranking Member Kevin Brady
Ranking Member Greg Walden

Committee on Ways & Means
Committee on Energy & Commerce
United States House of Representatives
Washington, D.C. 20515

Dear Chairmen Neal and Pallone and Ranking Members Brady and Walden:

The Blue Cross Blue Shield Association (BCBSA) is pleased to provide feedback to you and your staff on improvements to the Medicare Part D program and the bipartisan draft legislation released on May 23, 2019.

BCBSA is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield companies (Plans) that collectively provide healthcare coverage for one in three Americans. For 90 years, Blue Cross and Blue Shield companies have offered quality healthcare coverage in all markets across America – serving those who purchase coverage on their own as well as those who obtain coverage through an employer, Medicare and Medicaid.

We share the Committees' concerns about the high prices of prescription drugs and the financial burden it places on Medicare beneficiaries. We appreciate the opportunity to offer recommendations to improve beneficiary access to more affordable prescription drugs in the Part D program. Specifically, any reforms to the Part D program should:

- **Strengthen financial protections for beneficiaries by establishing a maximum out-of-pocket and preventing harmful premium increases.** BCBSA agrees with the Committees that establishing a maximum out-of-pocket (MOOP) is needed in the Part D program to protect beneficiaries with high drug costs. This should be done in a manner that protects beneficiaries from large premium increases and ensures continued program stability. It is critical any reform balance these competing interests.
- **Hold manufacturers accountable for drug prices.** Currently, manufacturers pay a discount on brand drugs in the coverage gap, but their liability is limited and does not place downward pressure on prices. Any changes to the Part D benefit structure must hold manufacturers, along with plans, responsible for total drug costs and aim to reduce costs for beneficiaries and the government.
- **Provide plans with necessary tools to manage benefit costs.** In order for Part D plans to effectively reduce cost in any form of Part D reform, Congress must reduce

obstacles that limit plans' ability to negotiate for the lowest price, direct consumers to the highest-value medications, and provide the type of management that can reduce harmful overutilization. This includes revisions to, or elimination of, the protected classes, which are long overdue for modernization.

Feedback on Draft Legislation

The language in the draft is generally aligned with proposals from the Medicare Payment Advisory Commission (MedPAC) in 2016, as well as the President's 2019 and 2020 budgets, and would create an out-of-pocket maximum on prescription drug costs in Part D based on the current catastrophic threshold as well as reduce the government's share of liability in the catastrophic phase from 80 percent to 20 percent.

BCBSA is concerned this approach would not achieve the Committees' goals of improving beneficiary access to affordable prescription drugs and strengthening the Part D program for a number of reasons. First, according to a recent analysis from Oliver Wyman, this policy would increase beneficiary premiums by more than \$25 billion and total government liability by more than \$91 billion over ten years.¹

Second, by increasing plan liability with no corresponding change to manufacturer liability, this approach does nothing to address the underlying cost of prescription drugs and fails to create federal savings. Although the proposed legislation achieves a MOOP, it does so in a way that results in increased federal costs. This increase is due to the fact that the Centers for Medicare and Medicaid Services (CMS) direct subsidy payments go up when premiums go up, since subsidy payments are equal to the difference between the national average bid amount and national average premium. Thus, the changes proposed to reinsurance in the Committees' draft would increase bids, and, therefore, both beneficiary premiums and federal payments would go up.

We believe it is critical for any reforms to the Part D program to make sure manufacturers are more accountable for total cost in the program. Some have stated that increasing plan liability in catastrophic would place more pressure on plans to manage the benefit and address utilization. However, these incentives are already in place and are inhibited by lack of flexibility to effectively direct consumers to high-value medications, discussed in more detail below. Further, as noted by MedPAC, nearly all of the growth in spending for high-cost enrollees has been due to increases in the average price per prescription filled.²

A more effective way to hold manufacturers accountable, as well as strengthen cost protections for beneficiaries while reducing federal costs and enabling plans to better manage the benefit, is achieved by creating MOOP, giving plans more tools to manage the benefit, and giving manufacturers more "skin in the game." The latter can be achieved in a number of ways, including by extending the current law discount into the catastrophic phase or by simplifying the benefit to eliminate the coverage gap phase and create a new catastrophic phase. In these scenarios, risk is fairly apportioned between manufacturers, plans and the federal government.

¹ Oliver Wyman. "Part D Catastrophic Coverage – Financial Implications of Restructuring Liability" (May 2019). <https://www.ahip.org/wp-content/uploads/Restructuring-the-CMS-Federal-Reinsurance-Program.pdf>

² MedPAC March 2019 Report to Congress. http://www.medpac.gov/docs/default-source/reports/mar19_medpac_ch14_sec.pdf?sfvrsn=0

In fact, BCBSA's initial analysis of a simplified benefit structure (with elimination of the coverage gap, a MOOP, and manufacturer discount in the catastrophic phase) suggests that the addition of manufacturer liability in the catastrophic phase could allow MOOP to be set below the current true out-of-pocket (TrOOP, which is \$6,350 in 2020) and still lead to lower premiums and significant savings to the federal government.

Finally, we note that the draft legislation would begin to implement these changes for plan year 2020. Given that bids have recently been submitted for 2020, this implementation date would not be feasible without significant disruption to the program. In addition, plans face uncertainty with respect to potential changes to Part D resulting from the Department of Health and Human Service Office of the Inspector General (HHS OIG) Safe Harbor rule, which has not yet been finalized. We recommend that any changes to Part D provide plans with sufficient time for successful implementation, take into account any interaction with other major program changes and ensure no disruption for beneficiaries.

Specific Questions from Committee

- 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.**

BCBS Plans provide Part D coverage to over 4.1 million Medicare beneficiaries (1.4 million in stand-alone prescription drug plans (PDPs) and 2.7 million in Medicare Advantage Prescription Drug Plans (MA-PDs)). We share the Committees' goals of lowering prescription drug costs and improving the structure of Part D for both beneficiaries and taxpayers.

Today, Part D health plans, primarily through pharmacy benefit managers (PBMs), negotiate with manufacturers to secure the lowest prices for prescription drugs and help beneficiaries gain access to medications through plan formularies. As a result of the current system, which enables health plans to negotiate drug prices and set formularies, premiums have been kept low – the average 2019 monthly PDP premium is \$41, and the average beneficiary has a choice of 27 PDPs and 21 MA-PDs.³ However, the current system has also resulted in individuals with high Part D costs incurring large costs in the catastrophic phase as well as rising federal costs.

Plans use a number of tools to control costs in the Part D program, including formulary placement and utilization management techniques, such as prior authorization and step therapy, to ensure beneficiaries have access to appropriate, affordable drugs for their condition. Plans set their formularies and utilization management tools in their bids in advance of the plan year and do not change them based on the phase of Part D coverage, including when beneficiaries enter or exit the coverage gap. Therefore, it is inaccurate to say that plans do not face strong incentives to control costs in all phases of the benefit, even if their liability is lower at certain points.

³ Medicare Part D: A First Look at Prescription Drug Plans in 2019. *Kaiser Family Foundation*. (October 2018). <https://www.kff.org/medicare/issue-brief/medicare-part-d-a-first-look-at-prescription-drug-plans-in-2019/>

BCBSA appreciates recent Administration efforts to provide additional tools and flexibility for plans to manage high-cost drugs and negotiate the best prices from manufacturers, such as indication-based formularies and step therapy in Part B. However, we believe there are other areas in which Congress could go further in a way that both maintains beneficiary protections while also achieving an increased ability for plans to direct consumers to high-value medications and reduce harmful overutilization. BCBSA supports the removal of the protected classes, as well as other plan flexibilities and tools, including the ability to offer a preferred and non-preferred specialty tier and the ability to offer one drug per category or class.

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.

Under the current Part D program, beneficiaries' cost-sharing varies based on the phase of the benefit. Beneficiaries pay 100 percent of the cost of their drugs in the deductible phase, 75 percent in the initial coverage phase and coverage gap (for brands), and then 5 percent in the catastrophic phase. While 5 percent seems low, it can result in staggering financial liability as the prices of high-cost specialty drugs continue to grow. A recent report from MedPAC found that in 2010, 33,000 Part D enrollees filled a prescription for which a single claim would have been sufficient to meet the out-of-pocket threshold. In 2016, that number jumped to 360,000.⁴ In addition, an Avalere analysis found that the number of non-low income subsidy (LIS) beneficiaries reaching the catastrophic phase increased by more than 50 percent between 2013 and 2014.⁵

BCBSA agrees with the Committees that there is a need to provide meaningful financial protections for beneficiaries who take high-cost medications. This should be balanced, however, against potential premium increases for all beneficiaries. As we noted in our comments in response to the HHS OIG Safe Harbor Proposed Rule, premium increases could incent beneficiaries with very low drug costs to drop coverage, negatively impacting the overall risk pool, and would also threaten the ability of MA-PDs to use their rebates to buy down the Part D premium as a supplemental benefit.

As noted above, BCBSA believes you can achieve both financial protections for beneficiaries and prevent harmful premium increases by ensuring manufacturers have more liability for the total cost of the benefit. Our initial analysis suggests that the addition of manufacturer liability in the catastrophic phase could allow a MOOP to be set below the current TrOOP (\$6,350 in 2020) and still lead to lower premiums and savings to the federal government.

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.

⁴ MedPAC Report To Congress (March 2019) Chapter 14: The Medicare Prescription Drug Benefit (Part D) Status Report

⁵ <https://avalere.com/press-releases/more-medicare-part-d-enrollees-are-reaching-catastrophic-coverage>

Nearly 30 percent of individuals enrolled in Part D receive low-income subsidies, which pay for Part D premiums and reduce cost-sharing. Cost-sharing for these beneficiaries is between \$1.25 and \$3.40 for generics and \$3.80 and \$8.50 for brand-name drugs in 2019.⁶ These beneficiaries use brands at a much higher rate than non-LIS beneficiaries, and they make up the majority of the beneficiaries with spending above the catastrophic phase.⁷ MedPAC research has found that plans have been less successful at encouraging LIS beneficiaries to use generics and has recommended stronger incentives for LIS beneficiaries to use generics when available.⁸

BCBSA supports proposals to lower LIS copayments for generic drugs and increase them for brand-name drugs. We disagree with variations of this proposal that would eliminate cost-sharing completely and, instead, recommend a reduction for generics and biosimilars to a nominal level while increasing cost-sharing for brands. This change could lead to significant cost-savings to the Medicare program and would complement other structural program changes the Committees are considering.

We appreciate your consideration of our comments. If you have any questions or want additional information, please contact Philip Hays at Philip.Hays@bcbsa.com or Jason Pray at Jason.Pray@bcbsa.com.

Sincerely,



Justine Handelman
Senior Vice President
Office of Policy and Representation

⁶ Announcement of Calendar Year (CY) 2020 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter.

⁷ Of the 3.6 million beneficiaries with spending above the catastrophic phase in 2015, 2.6 million received low-income subsidies and 1.0 million did not. <http://files.kff.org/attachment/Issue-Brief-No-Limit-Medicare-Part-D-Enrollees-Exposed-to-High-Out-of-Pocket-Drug-Costs-Without-a-Hard-Cap-on-Spending>

⁸ MedPAC June 2016 Report to Congress. <http://www.medpac.gov/docs/default-source/reports/chapter-6-improving-medicare-part-d-june-2016-report-.pdf>