TESTIMONY BEFORE THE SENATE SPECIAL COMMITTEE ON AGING

"10 Years Later: A Look at the Medicare Prescription Drug Program"

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Chairman Nelson, Ranking Member Collins, distinguished members of the Committee, on behalf of AARP's more than 37 million members, we thank you for holding this hearing on the Medicare Part D prescription drug program, which is helping millions of Medicare beneficiaries afford the prescription drugs they need. My name is Rob Romasco and I serve as AARP President.

AARP is pleased that this Committee is examining the progress of the Part D prescription drug benefit program as we mark its tenth anniversary. AARP continues its strong support of the Medicare drug benefit, which provides help to older persons and persons with disabilities, particularly those with low-incomes, those with catastrophic drug costs and those who have no other source of drug coverage.

Millions of prescriptions are being filled every day, and we know from our members that they are saving money as a result of the Medicare prescription drug coverage. AARP continues to support this vital coverage, and we look forward to working with members of the committee to continue to improve the program to both save money and improve health outcomes.

Improved Access to Prescription Drugs

Prescription drug coverage plays a vital role in the health and financial security of the older population. For older adults, prescription drugs are critical in managing their chronic conditions, curing diseases, keeping them healthy and improving their quality of life. The Medicare Part D program has truly been a success story in expanding access to prescription drug coverage for seniors. In general, survey analysis shows that seniors are very satisfied with the plan choices offered, their access to brand name and generic prescription drugs, and the affordability of their drugs with Medicare Part D coverage.[1] Since its implementation in 2006, the share of seniors with access to significant prescription drug coverage has increased from 75 percent to about 90 percent.[2] This includes persons who receive coverage through employer-sponsored retiree plans, the Veterans Administration, and other sources.

As part of the Patient Protection and Affordable Care Act (ACA), the initial Part D coverage gap is slowly being eliminated through a series of escalating discounts. According to the Center for Medicare and Medicaid Services (CMS), these changes – as well as a one-time $250 rebate for enrollees who hit the coverage gap in 2010 – have already saved Medicare Part D enrollees more than $5.1 billion on prescription drugs.[3]

The Part D program has also come in under budget, with the most recent figures showing the program's actual spending is about 30 percent lower than initial projections made by the Congressional Budget Office (CBO) in 2003 during consideration of the Medicare Modernization Act (MMA). The program's success is in part due to the competition among

[1] T. Keenan, *Prescription Drugs and Medicare Part D: A Report on Access, Satisfaction, and Cost*, AARP Knowledge Management, November 2007, http://www.aarp.org/health/drugs-supplements/info-2007/rx_medicare_d.html. MedPAC analysis of 2010 Medicare Current Beneficiary Survey Access to Care file, March 2013.
[2] MedPAC, *Report to Congress: Medicare Payment Policy*, Chapter 15, Status report on Part D, March 2013.
[3] CMS, "People with Medicare save $5 billion on prescription drugs thanks to the health care law," Press Release, December 3, 2012, http://www.cms.hhs.gov./apps/media/press_releases.asp.

multiple Part D plans. Consumers have the ability to choose between different options based on a range of criteria that meet their needs – such as premiums and cost-sharing, formularies, quality of services, and network adequacy – in order to make informed decisions about their prescription drug coverage. At the same time, several other factors have contributed to the Part D program's lower costs, including lower than projected enrollment, overall slower growth in prescription drug spending, increased use of generic drugs, expiration of many brand name drug patents since 2006, and fewer new drugs being approved by the Food and Drug Administration (FDA).[4]

Last year, new analysis by the CBO underscores the importance of prescription drug adherence on overall medical costs. CBO acknowledged for the first time the connection between taking medications and preventing hospital admissions and reducing the use of other medical services. In its review of the research, CBO found evidence of an offsetting effect of prescription drug use on spending for medical services. It now estimates that a 1 percent increase in the number of prescriptions filled by beneficiaries would cause Medicare's spending on medical services to fall by roughly one-fifth of 1 percent.[5] This new analysis shows the importance of the Part D program in helping to control spending elsewhere in the Medicare program.

AARP's Educational Efforts

Since the passage of the MMA, AARP has worked to provide information to our members and their families, as well as all Americans, about the changes to the Medicare program. AARP has produced numerous beneficiary-oriented publications explaining the Medicare Part D program. These publications are made available to our members and the public via the AARP website and our toll-free number. In addition, we have reached out to our members and the public at large with the information on the program through AARP's publications and the media. Our state and national offices conducted extensive education and outreach during implementation and in the run up to the initial enrollment deadline in 2006. We have particularly focused on outreach and education to low-income populations and encouraging those who may qualify to apply for the low-income assistance.

AARP and other consumer groups worked collaboratively with CMS and the Social Security Administration (SSA) to identify start-up problems in connection the program's implementation. Due to this important collaboration between government and stakeholders many of the initial problems and barriers to enrollment were addressed. However, the need for continued outreach and education on Part D remains as important as ever to ensure that seniors understand their options and receive appropriate drug coverage. According to a 2012 Kaiser Family Foundation National Survey, while the great majority of seniors (73 percent) say they are aware of the annual enrollment period and 60 percent say they

[4] J. Hoadley, *Medicare Part D Spending Trends: Understanding Key Drivers and the Role of Competition*, Kaiser Family Foundation Medicare Policy Issue Brief, May 2012.
[5] Congressional Budget Office, "Offsetting Effects of Prescription Drug Use on Medicare's Spending for Medical Services," November 29, 2012, http://www.cbo.gov/publication/43741.

compare their Medicare options as recommended, one in four seniors do not review their option routinely.[6]

Furthermore, despite CMS' commendable efforts to reduce the number of Part D plans that are available to enrollees, there is growing evidence that enrollees are still struggling to choose the best prescription drug plan to fit their needs. For example, research suggests that less than 10 percent of individuals enroll in plans that are optimal with respect to premiums and co-payments.[7] These choices can have serious financial implications: one study found that Part D enrollees spent an average of $368 more per year than they would have spent had they purchased the cheapest plan available in their region, given their medication needs, and more than one-fifth spent at least $500 a year more than needed.[8]

Continued outreach and education is critical so that seniors understand changes in their coverage and compare it with alternative options that might be more suited to their current medical needs or have lower out-of-pocket costs. AARP has also been actively involved in efforts with CMS to improve the Medicare Plan Finder. Refinements to the Medicare Plan Finder are needed to make it more user-friendly so that it can better assist Medicare beneficiaries as they analyze plan offerings to make informed decisions on selecting a plan.

Current Snapshot of the Medicare Part D Program

Medicare's outpatient prescription drug benefit, Part D, is a voluntary program available since 2006. Approximately 65 percent of Medicare beneficiaries participate. The standard Medicare Part D benefit consists of a deductible; an initial coverage period, in which enrollees are responsible for 25 percent of their prescription drug costs; a coverage gap, in which enrollees are responsible for a large, but declining part (due to the ACA provision that took effect in 2011) of their prescription drug costs; and catastrophic coverage, in which enrollees are responsible for 5 percent of their prescription drug costs. Enrollees who receive Part D's low-income subsidy (LIS) have very low and uniform cost-sharing throughout the year and do not face a coverage gap.

In 2013, enrollees fall into the coverage gap after their total prescription drug spending reaches $2,970 and enter catastrophic coverage after their total out-of-pocket spending reaches $4,750. More than 30 million Medicare beneficiaries were enrolled in Part D plans in 2012—with about 63 percent (19.7 million) in stand-alone plans (PDPs) and the remaining 37 percent (11.7 million) in Medicare Advantage plans with prescription drug coverage (MA-PDs).[9] An additional 6.2 million were in employer or union-sponsored plans with equal or better benefits, and more than 8 million had prescription drug coverage from the Department of Veterans Affairs and other sources. In 2013, there are a total of 1,033

[6] Kaiser Family Foundation, *Seniors' Knowledge and Experience with Medicare's Open Enrollment Period and Choosing a Plan*, October 2012 Issue Brief. www.kff.org

[7] F. Heiss et al., "Plan Selection in Medicare Part D: Evidence from Administrative Data," NBER Working Paper Series, June 2012.

[8] C. Zhou and Y. Zhang, "The Vast Majority Of Medicare Part D Beneficiaries Still Don't Choose The Cheapest Plans That Meet Their Medication Needs," *Health Affairs* Vol 31(1): 2259–2265.

[9] MedPAC, *Report to Congress: Medicare Payment Policy*, March 2013.

PDPs serving regional or national areas, as well as 1,627 MA-PDs. However, more than three-fourths of all Part D enrollees have historically gravitated to about a dozen national plans. That is, a few plans have a large majority of enrollees, with an average monthly premium (weighted for enrollment) of about $40.

Medicare Part D's most generous coverage is reserved for the roughly one-third of enrollees with incomes below 150 percent of federal poverty level who qualify for the LIS benefit. Indeed, MedPAC found that in 2010, 56 percent of program costs were devoted to covering these enrollees, who are more likely to have multiple chronic conditions.[10] About 10 to 14 percent of non-low-income subsidy enrollees reached the Part D coverage gap ("doughnut hole") each year from 2006 to 2010, where they faced the full cost of their prescription drugs, and less than 2 percent of those beneficiaries reached the catastrophic coverage level.[11] We know beneficiaries who reach the coverage gap may forgo needed medications, possibly leading to preventable adverse health outcomes, and higher overall Medicare costs.

Changes Made under the Affordable Care Act

The 2010 Patient Protection and Affordable Care Act (ACA) takes several important steps to protect current and future enrollees who fall into the coverage gap. In 2010 a $250 rebate was sent to all non-low-income subsidy (LIS) Part D enrollees who fell into the gap. Starting in 2011 the doughnut hole began to close through a combination of contributions from Part D enrollees, Medicare, and brand name drug manufacturers.

By 2020, non-LIS Part D enrollees will be responsible for 25 percent of their prescription drug costs throughout the time they meet their deductible to the time they enter catastrophic coverage, effectively eliminating the coverage gap. In addition, the growth rate for the Part D benefit's high catastrophic spending threshold, which is the amount a beneficiary must spend out-of-pocket before considerably lower coinsurance applies, will be slowed from 2014 through 2019. In 2020, the growth rate will again rise with enrollees' per capita drug spending.

The ACA also established a regulatory pathway that will allow the FDA to approve generic versions of biologic drugs, or biosimilars. Biologics, derived from living organisms, are in their early stages in the U.S., but are among the fastest growing and highest priced drugs. Such drugs, usually administered by injection, are increasingly used for chronic diseases that primarily affect older populations such as rheumatoid arthritis, multiple sclerosis, and certain cancers. These factors, combined with the current lack of generic alternatives, lead biologics to be among the most expensive prescription medicines on the market.

The ACA provides innovator biologic manufacturers with 12 years of market exclusivity before biosimilars can be approved. Presently, a very small but growing proportion of enrollees use these most expensive therapies, which are commonly assigned to a drug

[10] L. Summer, J. Hoadley, and E. Hargrave, *The Medicare Part D Low-Income Subsidy Program: Experience to Date and Policy Issues for Consideration*, Kaiser Family Foundation, September 2010. Also see, MedPAC Report, March 2013.
[11] C. M. Gbarayor, Ph.D., MPH, CMS Presentation, *Plan and Beneficiary Characteristics Associated with the Coverage Gap and Catastrophic Phase*, March 2012. http://www.cmsdrughealthplanevents.org/cms/index.php/events/cms-2012-medicare-prescription-drug-benefit-symposium/

plan's "specialty" tier. Within Medicare Part D, users of biologics and other specialty drugs pay coinsurance that ranges from 25 percent to 40 percent. These drugs' full costs can range from $1,500 per dose to tens of thousands of dollars, or more.

CMS has reported that while most enrollees who reach the coverage gap do so in mid-year, those using specialty drugs are likely to do so just a few months into the benefit year. Thus, they would quickly pass through to the catastrophic phase, where their drug costs are substantially covered by their plan and Medicare. While the trend nationally is for greater reliance on specialty drugs to treat chronic conditions, CMS last released a "top 10" list of such drugs for Part D enrollees based on the 2008 plan year. This prevents a timely analysis of current and projected cost trends in this area, at both the Medicare beneficiary and program level. One economic point is certain – specialty drugs' prices are rising at an annual rate of about 18 percent across all U.S. patients, a rate much faster than those of non-specialty drugs.[12]

Assistance for Low-Income Beneficiaries

Among the most important protections in Part D is the extra help provided by the low-income subsidy (LIS) to those least able to afford their drug costs. Around 11 million beneficiaries are currently receiving the LIS, but CMS has estimated that approximately 2 million other low-income beneficiaries are eligible but not receiving these subsidies. The LIS provides greatly reduced costs and no gap in coverage (no "doughnut hole") for beneficiaries with incomes below 150 percent of the federal poverty level ($17,235 for individuals in 2013).

We are pleased the LIS benefit is providing essential help with premiums and copays to millions who otherwise might go without lifesaving medicines because of cost. We commend CMS for providing auto- and facilitated enrollment in LIS for people enrolled in Medicaid, a Medicare Savings Program (MSP), or receiving Supplemental Security Income and deemed eligible for LIS. We also applaud CMS for waiving the late enrollment penalty for anyone found eligible for LIS. We similarly appreciate steps SSA has taken to minimize the burden of annual LIS eligibility redeterminations.

However, LIS protection has still not reached too many low-income beneficiaries. More than 2 million beneficiaries are eligible for low-income subsidies but not receiving them, a finding that has been attributed to a variety of factors.[13] AARP is concerned by new research, published this month, that found more than 42 percent of persons eligible for the LIS were not enrolled in Part D. Those at older ages, with poorer cognitive skills, and poorer ability in math skills were least likely to enroll.[14] One particular source of concern is the asset test. To be eligible for the LIS in 2013, beneficiaries can have no more than $13,300 in savings, or $26,580 for a couple, no matter how low their income or how high their other living expenses. These amounts are hardly enough to get people through retirement, and

[12] IMS Institute for Healthcare Informatics, *Declining Medicine Use and Costs: For Better or Worse? A Review of the Use of Medicines in the United States in 2012*, May 2013.
[13] L. Summer, J. Hoadley, and E. Hargrave, *The Medicare Part D Low-Income Subsidy Program: Experience to Date and Policy Issues for Consideration*, Kaiser Family Foundation, September 2010.
[14] I. Kuye, R. Frank, J. McWilliams, "Cognition and Take-Up of Subsidized Drug Benefits by Medicare Beneficiaries," JAMA Internal Medicine, (online) May 6, 2013. http://www.jamainternalmed.com

anyone who saved even one dollar over these limits is not eligible for LIS. That is why AARP has consistently opposed the asset test.

Asset tests directly contradict efforts to encourage people to save by penalizing those who, despite very limited incomes, manage to put away a small nest egg for retirement. We should encourage people to save for retirement, not penalize those who do. According to the SSA, nearly 30 percent of LIS application denials in 2007 were due in part to excess assets.[15] Asset tests are also a serious barrier to enrollment, even for those who meet its limits, because it makes the application process daunting and invasive. Part D enrollees may not understand what information is required; they may have difficulty obtaining the information; and the need to verify the information can be time-consuming.[16]

Medication Therapy Management

Another important Part D feature that can help enrollees get the most value from, and avoid problems with, their medications is medication therapy management (MTM) programs. AARP supports the role of MTM programs in helping targeted Part D patients to avoid drug-related problems. Unfortunately, MTM programs under Part D have met with mixed success so far despite positive return-on-investment with MTM in some programs outside of Part D.[17]

One of the most important parts of any MTM program is the comprehensive medication review, where a pharmacist or other MTM provider reviews all of a patient's medications, documents recommended changes, and communicates them to prescribers. Such a review is mandatory for all MTM-eligible persons. Older adults may have many reasons for not adhering to their treatment plans, such as: forgetfulness, complicated regimens, fear of side effects, and cost.

However, CMS reported that in 2010, only 8 percent of those eligible accepted a plan's invitation to receive a comprehensive medication review. Why are so few patients accepting this free service? AARP realizes that patients may be more responsive to an invitation for MTM services if issued from a doctor or community pharmacist, with whom a patient may have a trusted relationship – rather than from the drug plan, as is current practice.[18] Better integrating MTM into the doctor-patient encounter, rather than as a freestanding service that may not be offered until long after a prescription is filled (or not filled, if adherence is a problem), could help promote MTM's value across Part D.

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[15] GAO, *Medicare Part D Low-Income Subsidy: Assets and Income are Both Important in Subsidy Denials, and Access to State and Manufacturer Drug Programs is Uneven*, September 2008.

[16] L. Summer, J. Hoadley, and E. Hargrave, *The Medicare Part D Low-Income Subsidy Program: Experience to Date and Policy Issues for Consideration*, Kaiser Family Foundation, September 2010.

[17] A CMS pilot involving medication therapy management for Connecticut Medicaid patients found that almost a third of drug-related problems were due to inappropriate or unnecessary medications; and one-quarter were due to lack of adherence. Following several patient-pharmacist consultations to resolve many of these problems, the savings to CT Medicaid were found to be more than $1,120 per patient on drug costs, and over $470 per patient on medical, hospital, and emergency department expenses. M. Smith, "In Connecticut: Improving Patient Medication Management in Primary Care," *Health Affairs*, Vol. 30, No. 4 (April 2011), p. 646-654, http://content.healthaffairs.org/content/30/4/646.abstract?sid=9f006ebf-1d13-4c27-bb60-ae88ad7e59f4.

[18] N. Lee Rucker, *Medicare Part D's Medication Therapy Management: Shifting from Neutral to Drive*, AARP Public Policy Institute, June 2012. http://www.aarp.org/health/medicare-insurance/info-06-2012/medicare-part-d-mtm-AARP-ppi-health.html

Therefore, we are still learning a great deal about how Medicare Part D is affecting how people actually use medicines, and their effects on other costs of the Medicare program. For example, if drug-related problems cause a patient to land in the emergency room, or to undergo preventable procedures such as diabetic amputation, Medicare will likely incur those potentially larger downstream medical costs.[19]

Prescription Drug Safety

CMS has stated that Part D "must balance the need to combat fraud, waste and abuse and at the same time ensure our beneficiaries have sufficient access to medically necessary prescription drugs."[20] Examples of such possible fraud, waste and abuse were described in this month's *Pro Publica* investigation, "Dangers Found in Lack of Safety Oversight for Medicare Drug Benefit."[21] Better understanding and responding to such challenges are part of Part D's evolution. For AARP members and Part D enrollees, these challenges may not be transparent – but that makes them no less important. Part D plans must currently report to CMS on their performance on eight patient safety measures.

To enable more consistent oversight by CMS and Part D plans, AARP believes we should consider requiring academic detailing on specific classes of medicines that are prone to misuse or inappropriate use in populations of Part D enrollees. The Agency for Healthcare Research and Quality (AHRQ) already supports a National Resource Center for Academic Detailing, which works with both public and private organizations to address their specific needs.[22] We should also expand the charge for the U.S. Pharmacopeial Convention (USP) "Model Guidelines" role – currently conducted under contract to CMS, as specified in the law enacting Part D[23] – to provide unbiased guidance to plans on specific drug safety issues. With input from diverse stakeholders, the USP is charged with identifying categories and classes of drugs that can be used by Part D plans in developing their formularies.[24]

Areas of Concern

Cost-Sharing

Older Americans use prescription drugs more than any other segment of the U.S. population, and unfortunately many older Americans—particularly Medicare beneficiaries—continue to struggle to afford their prescription medications. In 2011, one-fifth of persons age 65 years and older asked their doctor for a lower-cost medication.

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[19] Nationally, poor adherence has been estimated to cost up to $290 billion/year, according to New England Healthcare Institute (NEHI).

[20] "Medicare Part D: Instances of Questionable Access to Prescription Drugs," Government Accountability Office, Sept. 2011, GAO-11-699, http://www.gao.gov/products/GAO-11-699

[21] *The Washington Post*, May 12, 2013, http://www.washingtonpost.com/national/health-science/dangers-found-in-lack-of-safety-oversight-for-medicare-drug-benefit/2013/05/11/067a10ae-b8ec-11e2-aa9e-a02b765ff0ea_story.html

[22] http://www.narcad.org/about/

[23] Medicare Modernization Act Section 1860D-4(b)(3)(C)(ii)

[24] http://www.usp.org/usp-healthcare-professionals/medicare-model-guidelines

That rate was even higher among near-poor older adults, with 24 percent requesting a lower cost alternative, according to the National Center for Health Statistics. Fortunately, Medicare Part D plans have helped to drive the overall generic prescribing rate from 61 percent in 2007 to 74 percent in 2010 (MedPAC, March 2013). However, the high cost of many brand name prescription drugs and associated cost-sharing can result in beneficiaries delaying or even failing to fill a prescription. According to a 2012 study by AARP's Public Policy Institute, the average annual increase in retail prices for 217 brand name prescription drugs widely used by Medicare beneficiaries was 8.3 percent in 2009. In contrast, the retail prices for 185 generic prescription drugs widely used by Medicare beneficiaries fell by an average of 7.8 percent.[25]

Making sure Part D beneficiaries can afford their prescriptions is essential as we continue to assess the program and how well it is working, and as we consider new policies to help further reduce costs. From the beneficiary perspective, Part D enrollees are now facing a more complex benefit structure than originally implemented. Nearly 70 percent of plans now have five or more different cost-sharing tiers. Where "preferred" and "non-preferred" designations previously were reserved for brand-name drugs, in some plans they are also applied to generics. In 2013, one-quarter of brand-name drugs require pre-approval (or "prior authorization") from the plan to use them, up from 20 percent in 2010.[26] Further, while recent years have featured some Part D plans offering deeply-reduced monthly premiums, per-prescription cost-sharing has increased. Since 2006, the median cost-sharing for a non-preferred brand-name drug has increased 67 percent, from $55 to $92 in 2012. Cost-sharing for "preferred" brand-name drugs increased 46 percent during the same period, from $28 to $41.[27]

Utilization Management

Prescription drug plans have increasingly relied on a variety of utilization management tools to control costs such as quantity limits, prior authorization, and step therapy to manage enrollees' use of formulary prescription drugs.[28] While AARP appreciates these efforts are helping to promote safe and appropriate use, we should remain vigilant that utilization management is being used appropriately and not negatively impacting enrollee access to necessary prescription drugs.

The Low-Income Subsidy

MedPAC recently reported that payments for the LIS population continued to be the largest component of Medicare Part D spending in 2011. In addition, a substantial share of other Part D spending categories also reflects benefits for LIS beneficiaries.[29] While AARP

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[25] S. Schondelmeyer and L. Purvis, *Rx Price Watch Report, Trends in Retail Prices of Prescription Drugs Widely Used by Medicare Beneficiaries 2005 to 2009*, AARP Public Policy Institute, March 2012. http://www.aarp.org/health/drugs-supplements/info-08-2010/rx_price_watch.html

[26] CMS presentation, "2013 Prescription Drug Plans," Dec. 2012.

[27] J. Hoadley, L. Summer et al., "Analysis of Medicare Prescription Drug Plans in 2012 and Key Trends since 2006," Kaiser Family Foundation, Sept. 2012. http://kff.org/health-reform/report/medicare-rx-drug-plans-2012-and-key-trends/

[28] L. Purvis and N. Lee Rucker, *Open Enrollment 2013: Medicare Part D Benefits Improve but Premiums and Cost-Sharing Rise in Many Popular Plans*, AARP Public Policy Institute Fact Sheet, November 2012. http://www.aarp.org/health/medicare-insurance/info-11-2012/open-enrollment-2013-medicare-AARP-ppi-health.html

[29] MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2013.

appreciates that LIS-related Part D spending is a source of concern, we believe recent recommendations to modify prescription drug copayments for LIS beneficiaries may be premature. Instead, we recommend that research be undertaken to help gain a better understanding of what is driving LIS beneficiaries' utilization in order to ensure that any proposed changes to the LIS benefit will not negatively impact low-income beneficiaries' access unnecessarily.

Income Related Premiums

The ACA added an income-related feature to the premiums for the Part D program, including a 10 year freeze on threshold levels, and further modifications to the current income-related premiums have been proposed as part of several deficit reduction plans. Under some proposals, the current freeze on income thresholds – starting at $85,000 for an individual and $170,000 for a couple – would be extended. If the income thresholds are frozen over a longer period of time, a growing share of elderly and disabled people who would not be considered high income by today's standards would face higher premiums.

AARP does not support making more Medicare Part D enrollees pay higher premiums based on their income. Seniors in Medicare have already paid into the system through payroll taxes—and those with higher incomes paid more into Medicare over their lifetimes. In many cases, seniors with higher incomes are still working and paying Medicare taxes—often because they do not have the savings they need to retire. Expecting them to pay more in premiums even as they continue to work and pay income and payroll taxes penalizes those who wish to work longer. AARP is also concerned that those with higher incomes may simply choose not to participate in the Medicare Part D program if asked to pay too much. This kind of risk selection could fundamentally change the nature and quality of the Medicare Part D program.

Appeals Process

AARP appreciates the improvements that were made to the Medicare Part D exceptions and appeals process as part of the ACA, which requires plans to have a single, uniform process and to provide instant access to this process through a website and toll-free number. However, AARP believes that additional changes could further help reduce enrollees' confusion and expedite the exceptions and appeals process. For example, plans could be required to provide a personalized notice at the pharmacy counter that provides a clear explanation of why a prescription was refused.

Additional Steps Needed to Reduce Costs

AARP has long-advocated for changes to the Medicare program that will help beneficiaries and improve the overall program. We urge Congress to enact legislation that will lower overall costs in the Part D program rather than adopt policies that reduce coverage or simply ask older Americans to pay more for their care.

Rebates

AARP supports the Medicare Drug Savings Act requiring prescription drug manufacturers to provide rebates for drugs provided to Medicare Part D LIS beneficiaries who are dually eligible for Medicare and Medicaid. Prior to the enactment of the MMA, dual-eligibles received their prescription drugs through the Medicaid program, and thus, their drugs were subject to mandated manufacturer rebates. A recent comparison of 100 brand name drugs under Medicaid and Medicare Part D found that Medicaid rebates required by law reduced expenditures by 45 percent for the drugs under review. By comparison, Medicare Part D rebates secured by private drug plans reduced expenditures by only 19 percent.[30]

AARP is pleased to support this legislation, which focuses on constructively reducing costs, and has been estimated to save $141 billion over the next ten years, without negatively impacting Medicare Part D benefits or shifting costs on to Medicare beneficiaries, half of whom live on annual incomes of $22,500 or less. AARP looks forward to working with all Members of Congress to enact this sensible legislation to improve the fiscal stability of the Medicare program while protecting beneficiaries.

Secretarial Negotiation

Currently, the Part D program relies upon negotiations conducted by individual prescription drug plan sponsors to obtain lower drug prices. AARP has consistently supported legislation that would enable the Secretary of Health and Human Services to use the bargaining power of Medicare's 49 million beneficiaries to further negotiate for lower prescription drug prices, which is especially important where there are no generic alternatives. More must be done to strengthen Medicare Part D plans' ability to secure lower prices for beneficiaries and the Medicare program.

Biologic Drugs

AARP supports reducing the exclusivity period for biologic drugs. Biologic drugs hold the promise of treating some of the most serious diseases—such as multiple sclerosis, rheumatoid arthritis, cancer and others—that often affect older populations. The daily costs associated with biologics are approximately 22 times higher than the daily costs associated with small molecule drugs[31]; annual costs for biologic drugs can reach as high as $400,000.[32] Persons who are prescribed biologic drugs—particularly those with chronic conditions who require such treatment indefinitely—may find the drugs unaffordable and decide to forgo them completely. The costs associated with biologic drugs are also a large and growing burden for federal programs like Medicare.

Specialty drugs, many of which are biologics, accounted for 10 percent, or $5.6 billion, of the $54.4 billion in total prescription drug spending under Medicare Part D plans in 2007. Among all Part D enrollees who used at least one specialty drug in 2007, 55 percent

[30] Department of Health and Human Services, Office of the Inspector General, *Higher Rebates for Brand-Name Drugs Result in Low Costs for Medicaid Compared to Medicare Part D*, August 2011.
[31] A.D. So and S.L. Katz, "Biologics Boondoggle." New York Times, March 7, 2010.
[32] M. Herper, "The World's Most Expensive Drugs," Forbes, February 22, 2010.

reached the catastrophic coverage threshold, after which Medicare pays at least 80 percent of all drug costs.[33]

The period of market exclusivity granted to brand name biologic manufacturers by the ACA is twelve years. AARP and many others, including the Federal Trade Commission, have long stated this period of exclusivity is excessive and serves to over-compensate brand-name biologic companies while keeping much-need biosimilar drugs from coming to market. Were the exclusivity period reduced from twelve years to seven years, it could result in billions of dollars in savings not only for beneficiaries and the Medicare program, but for employers and other health care payers.

Conclusion

The Medicare prescription drug benefit – including the closure of the Part D coverage gap – represents the most significant change to Medicare since the program began in 1965. The extra financial help provided to people who most need it through the LIS is a key component, but it is critical we eliminate the asset test that is penalizing people who save for retirement and imposing a barrier to enrollment in the LIS. In addition, reestablishing drug rebates like those obtained by Medicaid under the program and granting secretarial negotiating authority is needed to help keep the benefit more affordable as we move forward.

AARP stands ready to work with Congress to find ways to keep drug coverage affordable Medicare beneficiaries. However, we should focus on efforts to hold down costs and not efforts that simply shift costs in the form of higher premiums to certain beneficiaries. In addition, AARP opposes further income relating premiums or copayments that penalize saving and could begin to erode public support for this important program. Medicare's success has been largely attributed to its widespread acceptance by all providers and Americans across the income spectrum.

AARP is committed to strengthening the Part D drug benefit and working towards the enactment of responsible changes to improve access and reduce costs. We look forward to working with members of Congress from both sides of the aisle to improve the Medicare Part D prescription drug benefit and to ensure that all older Americans have access to affordable prescription drugs.

[33] GAO, *Spending, Beneficiary Cost Sharing, and Cost-Containment Efforts for High-Cost Drugs Eligible for a Specialty Tier*, January 2010.