



March 25, 2016

Francis J. Crosson, M.D.  
Medicare Payment Advisory Commission  
425 I Street, NW, Suite 701  
Washington, D.C. 20001

Dear Chairman Crosson,

The MAPRx Coalition brings together beneficiary, family caregiver and health professional organizations committed to improving access to prescription medications and safeguarding the well-being of beneficiaries with chronic diseases and disabilities under the Medicare prescription drug benefit (Part D). On behalf of millions of Medicare beneficiaries with chronic conditions who rely on Part D for essential medications, we write to share our concerns about MedPAC's proposals related to Medicare Part D.

The MAPRx Coalition has followed MedPAC's consideration of Part D policy recommendations, and we are writing to express our strong concern and opposition to several of the draft recommendations presented at your March meeting. A number of proposals the Commission plans to vote on at the next public meeting in early April would harm beneficiaries' access to needed medicines under the Part D benefit. Specifically, we ask that MedPAC reject proposals to: make changes to true out-of-pocket costs (TrOOP); increase copays for low-income subsidy (LIS) beneficiaries; and eliminate any of the protected classes.

**MedPAC's proposed TrOOP changes would widen the coverage gap and increase beneficiary out-of-pocket spending.** The Affordable Care Act (ACA) requires drug manufacturers to provide a 50% discount to beneficiaries on brand medicines in the coverage gap (also known as the "donut hole"). Congress specified that these discounts would be applied toward beneficiary out-of-pocket costs (true out-of-pocket costs or TrOOP) to ensure that beneficiaries progressed through the coverage gap and into the catastrophic phase of the benefit where they would have greater out-of-pocket cost protection. MedPAC's proposed recommendation to exclude these coverage gap discounts from Part D enrollees' TrOOP spending would significantly widen the coverage gap for beneficiaries and increase beneficiary out-of-pocket spending.

MedPAC is also considering a recommendation to eliminate enrollee cost-sharing above the out-of-pocket threshold along with these TrOOP changes. However, widening the coverage gap and increasing beneficiary out-of-pocket costs severely undermines the benefit of a hard out-of-pocket cap because

fewer beneficiaries would actually reach the out-of-pocket threshold to realize the benefit of this cost-sharing protection.

**While MAPRx supports MedPAC's recommendation to lower generic co-pays for LIS beneficiaries to \$0, the Coalition remains deeply concerned that as in years past, MedPAC will support increasing brand copays for beneficiaries receiving the LIS in Part D.** This proposal is punitive and will reduce access to necessary medications. Our understanding is that MedPAC has considered this change as a means to increase generic use among LIS beneficiaries. However, MedPAC's own data demonstrates high generic use rates for both LIS and non-LIS populations in Part D, with generic use steadily increasing for both groups since the program began in 2006. In 2013, 81% of LIS beneficiary prescriptions were filled with generics, versus 85% of non-LIS prescriptions, with generic use for LIS beneficiaries growing faster for 2012 to 2013 relative to non-LIS beneficiaries.

Relative to non-low income beneficiaries, LIS beneficiaries are in poorer health and often have multiple conditions or diseases and are more likely to be disabled. Due to the complexity of their conditions, LIS beneficiaries tend to fill more prescriptions than other beneficiaries. Taking multiple medications for several conditions increases the likelihood that one or more medicines will be a brand for which there is no generic equivalent or medically appropriate substitute. This makes LIS beneficiaries especially vulnerable to even small increases in copays for brand medicines.

Given that there is often a medical need for certain brand medicines and the very modest income and resources of LIS beneficiaries (below approximately \$1,336 monthly income for an individual in 2016), this policy unfairly targets the most vulnerable Part D beneficiaries. Further, increased brand copays would restrict treatment options. This could ultimately decrease patient adherence and increase spending on other health care services. CBO has recognized that policies that decrease the use of prescription medicines would cause Medicare medical spending to rise.

**MedPAC's proposal to eliminate two of the six protected classes will jeopardize access to Part D medications and we urge the Commission to reject this proposal.** MedPAC's proposed recommendation to remove anti-depressants and immunosuppressants for transplant rejection from the Part D protected classes revives a proposal that was rejected by the MAPRx Coalition, the broader patient advocacy community and bipartisan Members of Congress just two years ago.

Since implementation of the Part D benefit in 2006, the protected class policy has successfully ensured beneficiary access to critical drugs within the six protected classes. The protected class policy continues to effectively provide access to needed medications, and also mitigating complications associated with an interruption of care for vulnerable Medicare beneficiaries.

MedPAC must fully consider the unintended consequences of removing the protected status for antidepressant and immunosuppressant classes. Eliminating protected status for these two classes of drugs will result in an increase in beneficiary out-of-pocket costs and overall costs to the Medicare program. MAPRx believes that changes to the protected class policy could have a significant ripple effect on out-of-pocket costs for beneficiaries and additional costs within the Medicare system under Parts A and B. MedPAC must withdraw its proposal to alter the protected class policy and preserve beneficiary access to the antidepressant and immunosuppressant drug classes.

Notably absent from MedPAC's proposals are recommendations to address the significant and well-documented shortcomings of the Part D appeals process. Recent CMS audits have shown consistent failure by plans to efficiently adjudicate the appeals and grievance processes. Previous MedPAC analysis has also found that most beneficiaries are unaware of how the exceptions and appeals process works.

**MAPRx would like to take this opportunity to call on MedPAC to make recommendations to improve the Part D appeals process.** Important improvements would include: improving information provided to beneficiaries and prescribers in denial notices; explore treating a rejection at the pharmacy counter as a formal coverage determination; and improving and expanding transparency and data collection for Part D appeals.

The undersigned organizations appreciate the opportunity to comment on MedPAC's Part D policy proposals. The MAPRx Coalition requests a meeting to discuss our concerns in more detail, and specifically to share a new analysis of MedPAC's TrOOP proposal. For questions related to MAPRx or the above comments, please contact Bonnie Hogue Duffy, Convener, MAPRx Coalition, at (202) 540-1070 or [Bonnie@maprxinfo.org](mailto:Bonnie@maprxinfo.org).

Sincerely,

ADAP Advocacy Association (aaa+)  
AIDS Action Baltimore  
AIDS Alabama  
Allergy & Asthma Network  
Alliance for the Adoption of Innovations in Medicine (Aimed Alliance)  
Alpha-1 Foundation  
American Association on Health and Disability  
American Autoimmune Related Diseases Association  
American Behcet's Disease Association  
American Society of Consultant Pharmacists  
Asian & Pacific Islander American Health Forum  
Asthma & Allergy Foundation of America  
Caregiver Action Network  
Community Access National Network (CANN)  
COPD Foundation  
Crohn's and Colitis Foundation of America  
Dab the AIDS Bear Project  
Epilepsy Foundation  
GIST Cancer Awareness Foundation  
Global Colon Cancer Association  
HealthHIV  
HIV Dental Alliance  
International Foundation for Autoimmune Arthritis  
Lakeshore Foundation  
Lupus and Allied Diseases Association  
Lupus Foundation of America  
Men's Health Network  
Mental Health America  
National Alliance on Mental Illness

National Asian Pacific Center on Aging  
National Association of Nutrition and Aging Services Programs (NANASP)  
National Community Pharmacists Association  
National Council for Behavioral Health  
National Council of Asian Pacific Islander Physicians  
National Grange  
National Health Council  
National Kidney Foundation  
National Multiple Sclerosis Society  
National Organization for Rare Disorders (NORD)  
National Osteoporosis Foundation  
National Patient Advocate Foundation  
National Psoriasis Foundation  
Parkinson's Action Network  
Project ReDirect DC  
RetireSafe  
Salud USA  
The AIDS Institute  
The ALS Association  
The American Academy of HIV Medicine  
The Arc of the United States  
The Veterans Health Council  
U.S. Pain Foundation  
Vasculitis Foundation  
Vietnam Veterans of America

cc: MedPAC Commissioners  
Mark E. Miller, Ph.D