Leadership Council of Aging Organizations

Debra B. Whitman, Chair

December 6, 2019

The Honorable Nancy Pelosi, Speaker
The Honorable Kevin McCarthy, Minority Leader
United States House of Representatives
Washington, DC 20515

Dear Speaker Pelosi and Minority Leader McCarthy:

The Leadership Council of Aging Organizations (LCAO) is a coalition of 69 national nonprofit organizations concerned with the well-being of America's older adults and committed to representing their interests in the policy-making arena.

LCAO appreciates Congress's ongoing work to address the problem of high and rising prescription drug prices and to strengthen Medicare for people with disabilities and older adults, including H.R. 3, the *Elijah E. Cummings Lower Drug Costs Now Act of 2019*. This important bill would take significant steps to improve prescription drug access and affordability for people with Medicare. It would also reinvest the savings by extending coverage to dental, hearing, and vision services, which would greatly improve the quality of life for millions of beneficiaries, improve health outcomes, and further lower long-term costs. We urge members to pass the bill and move the process forward towards enactment of legislation that can be signed into law during this Congressional session.

Prescription drug affordability is an ongoing challenge for older adults. Currently, half of all Medicare beneficiaries—nearly 30 million people with disabilities and older adults—live on $26,200 or less per year, while one-quarter have incomes below $15,250 and less than $14,550 in savings.[1] Rising health care costs account for a disproportionate share of beneficiaries' limited budgets. In 2016, nearly 30% of Medicare households spent 20% or more of their income on health care, compared to only 6% of non-Medicare households.[2] Out-of-pocket costs for

[1] Jacobson, G., Griffin, S., Neuman, T., & Smith, K. (2017). *Income and assets of Medicare beneficiaries, 2016–2035* [Issue brief]. Retrieved from the Henry J. Kaiser Family Foundation Web site: https://www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2016-2035/

[2] Cubanski, J. Orgera, K., Damico, A., & Neuman, T. (2018).The financial burden on health care spending: Larger for Medicare households than for non-Medicare households. Retrieved from the Henry J. Kaiser Family Foundation Web site: https://www.kff.org/medicare/issue-brief/the-financial-burden-of-health-care-spending-larger-for-medicare-households-than-for-non-medicare-households/

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prescription drugs represent a significant share of this amount, accounting for nearly one out of every five beneficiary health care dollars.[3] A recent *Health Affairs DataWatch* survey found that 53% of seriously ill Medicare beneficiaries experienced considerable financial distress paying medical bills; of those, 30% stated that prescription drugs posed the greatest financial hardship.[4]

There is strong public support across party lines for Congress to take action to make prescription drugs more affordable. In a September Kaiser Family Foundation survey, 70% of respondents said that a top priority for Congress should be "lowering prescription drug prices for as many Americans as possible."[5] Similarly, in a September Gallup poll, 89% of respondents (86% of Republican respondents and 94% of Democrat respondents) believed that the consumer cost of prescription drugs was usually much higher (69%) or tended to be somewhat higher (20%) than what beneficiaries should pay.[6]

Immediate action is needed to reform the nation's drug pricing system in ways that will lower costs, strengthen Medicare, and promote the health and economic security of Medicare beneficiaries.

Medicare Part D Reforms

We support H.R. 3's efforts to lower drug costs for beneficiaries and reduce spending for the Medicare program. Among the bill's most important provisions are those allowing Medicare to negotiate drug prices for certain drugs; the imposition of inflationary rebates on drugs in Parts B and D; capping and smoothing cost sharing across the year for beneficiaries with high drug costs; improving low-income protections; and restructuring the benefit to improve alignment of pricing incentives.

We particularly appreciate and support provisions to reduce costs for beneficiaries with high out-of-pocket costs or low incomes. For example, the bill's $2,000 **cap on out-of-pocket costs** would provide much-needed relief to the growing number of beneficiaries with high drug costs. The percentage of beneficiaries shouldering out-of-pocket costs of at least $2,000 per year for brand-name drugs nearly doubled from 3.7% in 2011 to 7.3% in 2015.[7] In 2017, one million Medicare beneficiaries hit the catastrophic threshold and spent, on average, more than $3,200 on out-of-pocket drug costs.[8]

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[3] The Henry J. Kaiser Family Foundation (2019). *10 essential facts about Medicare and prescription drug spending* Retrieved from https://www.kff.org/infographic/10-essential-facts-about-medicare-and-prescription-drug-spending/

[4] Kyle, M. A., Blendon, R. J., Benson, J. M., Abrams, M. K., & Schneider, E. C. (2019). Financial hardships of Medicare beneficiaries with serious illness. *Health Affairs*,*38*, 1801–1806.

[5] Kirzinger, A., Kearney, Kearney, A., & Brodie, M. (2019). KFF Health Tracking Poll—Health care policy in Congress and on the campaign trail. Retrieved from the Henry J. Kaiser Family Foundation Web site: https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-september-2019/

[6] Witters, D. (2019). *Millions in U.S. lost someone who couldn't afford treatment*. Retrieved from the Gallup, Inc., Web site: https://news.gallup.com/poll/268094/millions-lost-someone-couldn-afford-treatment.aspx?version=print

[7] U.S. Department of Health and Human Services, Office of the Inspector General. (2018). *Increases in reimbursement for brand-name drugs in Part D* (Data brief OEI-03-15-00080). Retrieved from https://oig.hhs.gov/oei/reports/oei-03-15-00080.pdf

[8] Cubanski, J., Neuman, T., & Damico, A. (2019). *How many Medicare Part D enrollees had high out-of-pocket drug costs in 2017?* Retrieved from the Henry J. Kaiser Family Foundation Web site: https://www.kff.org/medicare/issue-brief/how-many-medicare-part-d-enrollees-had-high-out-of-pocket-drug-costs-in-2017/

We also applaud the inclusion of important improvements to the Part D **Low-Income Subsidy** (LIS). These changes would address major program shortcomings that impede access to needed assistance, such as (a) increasing LIS eligibility thresholds (H.R. 4620) and eliminating the asset test (H.R. 4628), (b) eliminating cost sharing on generics for LIS beneficiaries (H.R. 2757), improving notification to LIS enrollees regarding premium comparisons (H.R. 4632), (c) providing for intelligent assignment (H.R. 4669), (d) allowing U.S. territory residents to enroll in LIS (H.R. 4666), (e) expanding LIS autoenrollment (H.R. 4661), and (f) excluding certain retirement accounts from the program's income calculations (H.R. 4655).

We urge you to improve Medicare Part D even more by **simplifying the appeals process**, which is an essential program that enables people with disabilities and older adults to obtain needed prescriptions. Flaws in the current appeals process can lead to delays in access to medications, abandonment of therapies, reduced adherence to treatment protocols, worsened health outcomes, and higher costs. We urge you to address these challenges by including H.R. 3924, which would allow a refusal at the pharmacy counter to serve as the plan's initial coverage determination. This simple change would give people with Medicare more timely information about their plan's coverage decision and eliminate unnecessary steps within the appeals process.

Other Medicare Improvements

We also support reinvesting the realized Medicare savings into landmark benefit improvements. Original Medicare does not cover most dental, vision, and hearing care, which makes access to these benefits—either through some Medicare Advantage (MA) plans or other means—generally quite limited and inconsistent for most people with Medicare. Without teeth to eat and speak, hearing aids to communicate and engage, or glasses to see and travel, older Americans are more prone to social isolation, dementia, and complications from chronic conditions. Studies show that social isolation, in and of itself, is associated with an estimated $6.7 billion in additional Medicare spending annually.[9] Moreover, preventable oral infections in people with diabetes are responsible for millions of dollars in care,[10] while hearing loss was associated with an average 46% increase in a person's health care costs over ten years.[11] The cost of vision loss and related lost productivity is estimated to exceed $35 billion per year.[12] The absence of meaningful coverage for these basic health needs represent major gaps in Medicare's benefit structure—gaps that can leave people with disabilities and older adults on fixed incomes with unaffordable costs and poor health outcomes.

[9] Flowers, L., Houser, A., Noel-Miller, C., Shaw, J., Bhattacharya, J., Schoemaker, L., & Farid, M. (2017). *Medicare spends more on socially isolated older adults.* Retrieved from the AARP Public Policy Institute Web site: https://www.aarp.org/ppi/info-2017/medicare-spends-more-on-socially-isolated-older-adults.html

[10] Harvard School of Dental Medicine Initiative to Integrate Oral Health and Medicine. (2019). *Combining dental with medical insurance may lower health care costs: Executive statement* [Policy brief]. Cambridge, MA: The President and Fellows of Harvard College.

[11] Reed, N. S., Altan, A., Deal, J. A., Yeh, C., Kravetz, A. D., Wallhagen, M., & Lin, F. R. (2018). Trends in health care costs and utilization associated with untreated hearing loss over 10 years. *JAMA Otolaryngology-Head and Neck Surgery, 145*, 27–34. doi:10.1001/jamaoto.2018.2875

[12] Rein, D. B., Zhang, P., Wirth, K. E., Lee, P. P., Hoerger, T. J., McCall, N., Saaddine, J. (2006). The economic burden of major adult visual disorders in the United States. *Arch Ophthalmology, 124,* 1754–1760. doi:10.1001/archopht.124.12.1754 [Full article available to the public at https://jamanetwork.com/journals/jamaophthalmology/fullarticle/418866

We support reinvestments that would help address these unmet needs—ideally, by adding comprehensive **dental, vision, and hearing coverage** to Medicare Part B. H.R. 4650, H.R. 4665, and H.R. 4618 are significant first steps, and we urge the committees to consider strengthening these bills in the final package to move toward more comprehensive coverage that is aligned with other Part B benefits.

In addition, the **Medicare Savings Programs** (MSPs) help beneficiaries with limited incomes and savings to afford needed care under Medicare Parts A and B. However, strict MSP eligibility requirements unduly limit access to this critical assistance, making it difficult to enroll and leaving many who need help unable to qualify for it. To ensure that more beneficiaries can afford coverage and access high-quality care, we support expanding MSP eligibility, simplifying enrollment into the programs, and improving retroactivity (H.R. 4671).

Furthermore, we urge you to improve Medicare by passing legislation introduced to strengthen rules for supplemental **Medigap policies**, which help a growing number of people with Medicare[13] afford needed care. Too many beneficiaries in need are not eligible to buy this protection, and most are only guaranteed the right to do so during very limited time frames.[14] We support ensuring that beneficiaries of all ages and abilities have access to affordable, high-quality Medigap policies and the opportunity to reevaluate their coverage as their needs change. This includes extending guaranteed issue to all people with Medicare and facilitating transitions from MA (H.R. 4676).

Finally, in order to reduce health disparities and empower beneficiaries with limited English proficiency, we support translating important Medicare notices and information—including the *Medicare & You* handbook—into **additional languages** (H.R. 4675).

[13] MedPAC. (2017). *Trends in Medigap enrollment, 2010 to 2015*.MedPAC Blog. Retrieved from http://www.medpac.gov/-blog-/trends-in-medigap-enrollment-2010-to-2015/2017/02/13/trends-in-medigap-enrollment-2010-to-2015

[14] Boccuti, C., Jacobson, G., Orgera, K., & Neuman, T. (2018). Medigap enrollment and consumer protections vary across states. Retrieved from the Henry J. Kaiser Family Foundation Web site: https://www.kff.org/medicare/issue-brief/medigap-enrollment-and-consumer-protections-vary-across-states/

Thank you for your leadership and consideration. We urge you to seize this opportunity to invest in landmark Medicare improvements, rein in high and rising prescription drug prices, lower out-of-pocket costs for people with disabilities and older adults, and improve the Part D appeals process. We look forward to working together to advance these long-overdue and much-needed reforms.

Sincerely,

AARP
Aging Life Care Association
Alliance for Retired Americans
American Association of Service Coordinators
American Geriatrics Society
American Society on Aging
Association for Gerontology and Human Development in Historically Black Colleges and Universities (AGHDHBCU)
B'nai B'rith International
Caring Across Generations
Center for Medicare Advocacy
Community Catalyst
Consumer Voice
Families USA
International Association for Indigenous Aging
Justice in Aging
LeadingAge
Medicare Rights Center
National Adult Day Services Association (NADSA)
National Adult Protective Services Association
National Association of Area Agencies on Aging (n4a)
National Association of Social Workers (NASW)
National Association of State Long-Term Care Ombudsman Programs (NASOP)
National Caucus and Center on Black Aging
National Committee to Preserve Social Security and Medicare (NCPSSM)
National Council on Aging (NCOA)
Pension Rights Center
Sage
Service Employees International Union
Social Security Works
The Gerontological Society of America
Volunteers of America
Women's Institute for a Secure Retirement (WISER)

Cc: Members of the U.S. House of Representatives