Alliance FOR AGING RESEARCH
Catalyzing Innovation for Healthy Aging

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Speaker of the House Nancy Pelosi
United States House of Representatives
H-222, The Capitol
Washington, D.C. 20515

Majority Leader Mitch McConnell
United States Senate
317 Russell Senate Office Building
Washington, D.C. 20510

Minority Leader Rep. Kevin McCarthy
United States House of Representatives
H-204, The Capitol
Washington, D.C. 20515

Minority Leader Chuck Schumer
United States Senate
322 Hart Senate Office Building
Washington, D.C. 20510

Dear Speaker Pelosi, Senate Majority Leader McConnell, House Minority Leader McCarthy, and Senate Minority Leader Schumer,

The Alliance for Aging Research, www.agingresearch.org, is the leading nonprofit organization dedicated to accelerating the pace of scientific discoveries and their application to vastly improve the universal experience of aging and health. We would like to express our appreciation for your leadership in seeking to address the rising cost of healthcare for America's older adults, starting with reducing out-of-pocket costs for prescription drugs.

Older adults can face substantial out-of-pocket healthcare costs in a given year for insurance premiums, deductibles, and cost-sharing; physician and clinic visits; hospital stays; and other healthcare procedures, medical devices, and services not covered, such as vision, dental, and hearing-related services. The totality of these out-of-pocket costs can be insurmountable for older adults who often have multiple chronic and life-threatening diseases especially for the one in two Medicare beneficiaries who are living on an annual per capita income of less than $26,200.[1]

We encourage policymakers to take a collective leap forward in reducing beneficiary costs at the pharmacy counter by combining ideas from the current Senate and House proposals. For your ease of review, the first section outlines the provisions we support, the second section details provisions that we oppose, and the third section contains additional provisions we would like included in the package going forward.

[1] Jacobson, Gretchen. Income and Assets of Medicare Beneficiaries, 2016-2035. Kaiser Family Foundation, 2017, Income and Assets of Medicare Beneficiaries, 2016-2035, https://www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2016-2035/.

SECTION I: WHAT WE SUPPORT

Adding an Annual Out-of-Pocket Limit to Part D

The Medicare Part D program provides vital access to prescription medications for the more than 47 million beneficiaries enrolled in the program in 2019.[2] A July 2019 survey by *Morning Consult*, commissioned by our organization, found that over half of older adults age 65 and older on Medicare (54 percent) are very satisfied with their current health insurance coverage, compared to 34 percent of adults ages 60-64.[3] A separate 2018 survey, also by *Morning Consult*, found that 8 in 10 beneficiaries believe their prescription drug plan is a "good value."[4] The Part D program is successful and working for the vast majority of individuals enrolled in the program.

However, despite Part D's long record of success, there are still millions of beneficiaries who every day are having difficulty affording their prescription medications. One in five older adults age 60 and older report they are struggling to pay for prescription drugs—and, of those who have at least one chronic condition, nearly one in four (24 percent) report they have stopped taking a prescription medication because of the cost.[5] Not filling, delaying, or curtailing the use of prescription medications can have life-threatening consequences. The inability to pay for out-of-pocket costs can often make the difference between health and sickness and, in some cases, lead to lost independence and even death. While the creation of the Part D program has helped make prescription drugs more accessible and affordable for most beneficiaries who, prior to the advent of the benefit had limited or very expensive access to prescription drugs, years later, *it is the only type of health insurance in America that does not have a limit on out-of-pocket expenses such as deductibles and copays, keeping access out of reach for many of those most in need of treatment.*

We are pleased that committee leaders in both chambers of Congress have proposed changing this by redesigning the benefit to include a cap. As you know, the Senate has proposed an annual cap of $3,100, while the proposal in the House of Representatives includes a cap of $2,000 that also eliminates cost-sharing in the catastrophic phase of the benefit.

There is substantial support for this. Our July 2019 *Morning Consult* survey found that 75 percent of adults support a cap or limit to what beneficiaries pay out-of-pocket in the Medicare Part D program. And when asked to choose between a monthly and an annual cap, 46 percent of older adults support a monthly cap versus 24 percent who support an annual cap.[6]

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[2] 2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2019.pdf.

[3] "New Survey Shows Older Adults Are Willing to Pay More in Monthly Medicare Premiums to Ensure a Cap on Out-Of-Pocket Prescription Drug Costs." Alliance for Aging Research, 16 July 2019, www.agingresearch.org/press-release/new-survey-shows-older-adults-are-willing-to-pay-more-in-monthly-medicare-premiums/.

[4] Medicare Today. 2018 Senior satisfaction survey. http://medicaretoday.org/wpcontent/uploads/2016/07/8.13.18-Senior-Satisfaction-Survey-Fact-Sheet-NL-002.pdf. Published August 2018.

[5] Ibid.

[6] "New Survey Shows Older Adults Are Willing to Pay More in Monthly Medicare Premiums to Ensure a Cap on Out-Of-Pocket Prescription Drug Costs." Alliance for Aging Research, 16 July 2019, www.agingresearch.org/press-release/new-survey-shows-older-adults-are-willing-to-pay-more-in-monthly-medicare-premiums/.

The current absence of an out-of-pocket limit exposes Medicare beneficiaries to potentially devastating costs that can jeopardize their finances and health. An annual cap on Part D out-of-pocket expenses will help ensure that beneficiaries can access the drugs they were prescribed, and that allow them to live healthier, more productive lives. The Alliance supports both the Senate and House proposals that place an annual cap on out-of-pocket costs for Medicare Part D beneficiaries, and we favor the House bill's $2,000 lower cap threshold.

Smoothing Out OOP Expenses/Fixing the "Seasonality" of Triggering Catastrophic Coverage

Even if an out-of-pocket cap becomes part of the Part D benefit design, beneficiaries taking high-cost medications can bear a significant financial burden at the beginning of a plan year. This is because the cost of some medications can "burn through" the enrollee's deductible, as well as the initial coverage phase very quickly. These individuals might benefit from additional policies that reduce their monthly expenditures.

Analysis by Avalere found that approximately 3.6 million beneficiaries (8 percent of all Medicare Part D enrollees) hit the catastrophic phase of their benefit in 2017, with 800,000 of those not eligible for the low-income subsidy (LIS), and these beneficiaries were then responsible for their full cost-sharing, which averaged approximately $4,000 in yearly costs.[7] The analysis further found that of the 800,000 non-LIS enrollees, 350,000 experienced at least one month of out-of-pocket spending for prescriptions that exceeded $1,000 prior to reaching the catastrophic phase, and nearly 150,000 had at least one month in which out-of-pocket costs for prescriptions exceeded $2,500.[8] High out-of-pocket costs in a short period can create an affordability barrier for many beneficiaries, which in turn, can result in decreased medication adherence and poorer outcomes.

Patients with higher out-of-pocket expenses are also more likely to abandon a newly prescribed medication at the pharmacy. For example, a study on tyrosine kinase inhibitors used in chronic myeloid leukemia found that non-LIS patients facing $2,600 in cost-sharing were less likely to initiate medication within six months and took twice as long to initiate treatment.[9] Similar trends were found for non-LIS patients with metastatic renal cell carcinoma.[10]

As part of changes made to H.R. 3, Rep. Anna Eshoo (D-Calif.), chair of the House Energy and Commerce Health Subcommittee, sought to address those high upfront costs by including a "smoothing" mechanism to help Medicare Part D beneficiaries spread out high upfront costs over time. Similarly, Sens. Bill Cassidy (R-La.) and Bob Menendez (D-N.J.) introduced a bipartisan proposal that would accomplish the same aim.

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[7] Employer group waiver plans (EGWPs) are Part D plans offered by employers to their retirees that often have more generous benefits with lower cost sharing requirements than standard Part D plans. Avalere's analysis therefore focuses on the nearly 800,000 non-LIS, non-EGWP beneficiaries who reached catastrophic in 2017.

[8] Out-of-Pocket Costs Among Medicare Part D Enrollees Reaching the Catastrophic Threshold. Avalere, 2019, Out-of-Pocket Costs Among Medicare Part D Enrollees Reaching the Catastrophic Threshold, https://avalere.com/insights/issue-brief-oop-costs-among-medicare-part-d-enrollees-reaching-the-catastrophic-threshold

[9] Doshi, J.a. "Medicare Part D Cost Sharing And Specialty Drug Initiation In Newly Diagnosed Chronic Myeloid Leukemia Patients." Value in Health, vol. 19, no. 3, Mar. 2016, doi:10.1016/j.jval.2016.03.035.

[10] Li, Pengxiang. "Association of High Cost Sharing and Targeted Therapy Initiation among Elderly Medicare Patients with Metastatic Renal Cell Carcinoma." Cancer Medicine, vol. 7, no. 1, 2017, pp. 75–86., doi:10.1002/cam4.1262.

The Alliance supports the "smoothing" mechanisms being considered in both the House and Senate that would allow a beneficiary to pay their out-of-pocket high drug bills over the course of a plan year. The Part D annual out-of-pocket cap, combined with a way to smooth costs over time, will go even further for Medicare beneficiaries by helping them manage the cost of their care.

Broadening LIS Eligibility

The Medicare Part D Extra Help program also referred to as the low-income subsidy program or LIS, is administered by the Social Security Administration and was created to help people with limited incomes pay for all or some of the costs of a Medicare prescription drug plan—including premiums, annual deductibles, and copayments. According to the Kaiser Family Foundation, in 2019, nearly 13 million Part D enrollees—approximately 3 in 10—are receiving premium and cost-sharing assistance through the Part D LIS program.[11]

Because the LIS eligibility criteria for assets and income are low, less than 150 percent of the federal poverty line, only a small portion of economically vulnerable Medicare beneficiaries qualify for the program. Millions of financially vulnerable Medicare beneficiaries do not qualify for the program. In fact, the LIS standards are so stringent that the share of Part D enrollees receiving low-income subsidies has declined over time, from 42 percent of Part D enrollees in 2006 to 28 percent in 2019. Often beneficiaries lose their eligibility because they do not return the required paperwork to the Social Security Administration or their state Medicaid agency to maintain eligibility rather than because of changes in income or assets.

The Alliance applauds the inclusion of proposed improvements to the Part D LIS program in the House bill. Provisions to increase the eligibility thresholds for the LIS program; eliminate cost-sharing for generic therapies for LIS beneficiaries; intelligently assign beneficiaries to a plan in their geographic area based on their individual prescription drug needs, and eliminate the asset test for LIS will greatly strengthen the program and help many older adults who are in financially vulnerable situations but do not currently qualify for the LIS program.

Moderating Drug Prices

America's older adults are all too familiar with having the price of their prescription medication dramatically increase from year-to-year. According to an analysis by the Kaiser Family Foundation, of the 2,879 reported brand-name and generic drugs covered by Part D plans, 60 percent had list price increases that exceeded the inflation rate between July 2016 and July 2017, which was 1.7 percent.[12] When the list price of a drug increases over a short duration of time beneficiaries will have to pay more for their medications through cost-sharing.

To address this issue, both the Senate and House include proposals that would require manufacturers to pay a rebate to the Treasury Department if they raised the prices of a Medicare B or Part D drug above

[11] 10 Things to Know About Medicare Part D Coverage and Costs in 2019, https://www.kff.org/medicare/issue-brief/10-things-to-know-about-medicare-part-d-coverage-and-costs-in-2019/.
[12] Cubanski, Juliette, and Tricia Neuman. "Assessing Drug Price Increases in Medicare Part D and the Implications of Inflation Limits." Kaiser Family Foundation, 18 Oct. 2019, www.kff.org/medicare/issue-brief/assessing-drug-price-increases-in-medicare-part-d-and-the-implications-of-inflation-limits/.

the rate of inflation. The Congressional Budget Office estimates that the House proposal, which includes the rate of inflation since 2016, would reduce beneficiary spending in cost-sharing and premiums by $10 billion over a 10-year period[13]. It is expected that such a policy would better be able to help beneficiaries anticipate the amount they would spend out-of-pocket for drugs each year by providing a more stable basis for pricing.

To assure price stability, a similar policy is currently in place in the Medicaid program, whereby manufacturers participating in the Medicaid program must pay rebates to state Medicaid departments as an offset for drug spending. A component of the rebate is an inflationary rebate that requires manufacturers to issue an additional rebate when average manufacturer prices for a drug increase faster than inflation, as measured by the Consumer Price Index for All Urban Consumers (CPI-U). The total rebate amount is capped at 100 percent of the average manufacturer price. Analysis by Georgetown University Health Policy Institute found the Medicaid Drug Rebate Program lowered Medicaid prescription drug costs by more than 51.3 percent, compared to 19.9 percent rebate savings in Medicare Part D[14]. However, it should be noted there is a ceiling on the inflation adjustment in Medicaid, so the incentive for manufacturers to increase prices rapidly is limited.

The Alliance for Aging Research would support a provision that would help stabilize the prices of prescription drugs in Part D by minimizing unjustified large price increases.

Facilitating Full Colorectal Cancer Screening Coverage

The Alliance appreciates that House bill includes language to fix a "coverage glitch" concerning colorectal cancer screening. Currently, Medicare covers colonoscopies for beneficiaries without cost-sharing. However, if during screening precancerous polyps are discovered and removed, a beneficiary will have a 20 percent cost-sharing obligation. The removal of these polyps prevents cancer and a person will not know that they have polyps until they are screened through a colonoscopy.

The Medicare program should not have disincentives for beneficiaries to be screened for colorectal cancer. If this form of cancer is caught in a late-stage, the five-year survival rate is 14 percent. If caught early, the survival rate increases to 90 percent.[15]

Additionally, these screenings have a high potential to reduce Medicare spending. It is estimated that in the United States $14 billion is spent on colorectal cancer treatments with Medicare paying for up to half of that total.[16] It is cost-effective to incentivize and facilitate screening to prevent the development of this cancer.

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[13] Sections 121 and 128 (the Part D "Redesign" and "Inflation-Rebate" Provisions) of the Prescription Drugs Pricing Reduction Act. Congressional Budget Office, 2019, Sections 121 and 128 (the Part D "Redesign" and "Inflation-Rebate" Provisions) of the Prescription Drugs Pricing Reduction Act, www.cbo.gov/system/files/2019-07/Expected_Effects.pdf.
[14] Park, Edwin. How to Strengthen the Medicaid Drug Rebate Program to Address Rising Medicaid Prescription Drug Costs. Georgetown University Health Policy Institute, 2019, How to Strengthen the Medicaid Drug Rebate Program to Address Rising Medicaid Prescription Drug Costs, ccf.georgetown.edu/wp-content/uploads/2019/01/Medicaid-Rx-Policy-Options-v4.pdf.
[15] American Cancer Society. *Cancer Facts and Figures 2019.* Atlanta: American Cancer Society; 2019.
[16] Mariotto AB, Yabroff KR, Shao Y, Feuer EJ, Brown ML. Projections of the cost of cancer care in the United States: 2010-2020. J Natl Cancer Inst. 2011; 103(2):117-28.

SECTION II: WHAT WE OPPOSE

International Pricing Index (IPI), Use of the Quality-Adjusted-Life-Year (QALY), and Reliance on ICER

The Alliance considers the provisions in Title I of the House bill, known as the International Pricing Index (IPI), particularly worrisome. First proposed by U.S. Health and Human Services Secretary Alex Azar in the fall of 2018 for Medicare Part B drugs, the House's proposed drug pricing plan expands it to allow the federal government to negotiate the cost of 250 prescription medicines that aren't facing market competition. It also extends the negotiated price to insurers and the commercial market at large.

While price competition with other countries seems reasonable on its face, in practice it would have a disproportionately negative effect on companies that have newer or more innovative products on the market, often for what are the most challenging diseases. The IPI would also effectively endorse the use here in the U.S. of discriminatory cost-effectiveness standards used by foreign governments. Many of the referenced countries, such as the U.K., Canada, and Greece, make drug reimbursement and coverage decisions based on cost-effectiveness assessments tied to the quality-adjusted life-year (QALY). These QALY assessments assign a financial value to the patients for whom a given treatment is intended.

If the group is sicker, older, and/or disabled, the value is less. When applied to health care decision-making, the results can mean that some patients, people with disabilities, veterans, and seniors are deemed "too expensive" to receive care.

QALYs originated in the 1960s when the British government was searching for ways to ration health care for its National Health Service. This is an important premise to recognize—if we embrace the IPI, we are embracing health care rationing. Rationing in European countries has not only resulted in access issues but also translates into higher mortality in chronic diseases such as cancer and cardiovascular disease.

The Alliance is a member organization of the Partnership to Improve Patient Care (PIPC), which has been at the forefront of applying principles of patient-centeredness to the nation's health care system. In December 2018, PIPC sent a letter to Secretary Azar expressing concerns regarding the Center for Medicare & Medicaid Services' (CMS) proposed rule to utilize an IPI to set reimbursement for medicines in Medicare Part B. The letter stated:

> We are very concerned that, in adopting this construct, the Centers for Medicare and Medicaid Services would undermine core protections against discrimination for patients, people with disabilities, veterans, older adults, and others. In particular, the Affordable Care Act (ACA) very clearly states that the Secretary of Health and Human Services has no authority to deny coverage of items or services "solely on the basis of comparative effectiveness research" nor to use such research "in a manner that treats extending the life of an elderly, disabled, or terminally ill individual as of lower value than extending the life of an individual who is younger, nondisabled, or not terminally ill."[17]

[17] 42 USC Sec 1320e, 2017.

The ACA specifically prohibits the development or use of a "dollars-per-quality adjusted life year (or similar measure that discounts the value of a life because of an individual's disability) as a threshold to establish what type of health care is cost-effective or recommended."[18] Additionally, "The Secretary shall not utilize such an adjusted life year (or such a similar measure) as a threshold to determine coverage, reimbursement, or incentive programs under title XVIII" (Medicare)."[19]

Even prior to the ACA, Section 504 of the Rehabilitation Act ensured that individuals with disabilities would not "be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination," under any program offered by any Executive Agency, including Medicare.[20] Title II of the Americans with Disabilities Act (ADA) extended this protection to programs and services offered by state and local governments.[21] In 1992, the Administration, under President George H.W. Bush, established that it was a violation of the ADA for states to employ cost-effectiveness standards in Medicaid out of concern that it would discriminate against people with disabilities.[22]

The Alliance appreciates that the latest version of the House bill includes language to protect patients from discriminatory use of comparative effectiveness research. However, the bill does not include language expressly prohibiting the use of "a dollars-per-quality adjusted life year", or QALY, and continues to import the discriminatory QALY cost-effectiveness assessments and similar average metrics from other countries.

The Congressional Budget Office estimates of cost savings in the House bill are based on Institute for Clinical Economic Review (ICER) assessments, which rely on deeply flawed cost/QALY thresholds to make value judgments on drugs and other clinical options. The Alliance is opposed to the use of ICER reports as either the basis of or to inform discussions on the value of prescription medicine. In September 2018, the actuarial firm Milliman released a white paper on the utility of these reports for making cost-effectiveness assessments. The limitations of the ICER reports include:

- ICER does not consider the potential impact of a new drug on prices for existing drugs. Historically, the prices of existing drugs may go up or down after competitor drugs are launched depending on the competitive response and negotiations with payers.
- ICER understates the true budget impact of the medical savings of new therapies. ICER analysis anticipates medical savings and nets them against drug costs, and while some payers may benefit from medical savings, other payers, such as Part D plans, do not.
- ICER does not utilize real-world data consistently when estimating incremental cost determinations. The base year needs to use real-world data, some of which is confidential and/or unique to particular payers and plans.
- ICER does not consider the current market share of existing therapies when analyzing the incremental cost of a new therapy.

[18] Ibid.
[19] Ibid.
[20] 29 USC Sec 794, 2017.
[21] 42 USC Sec 12131, 2017.
[22] See https://www.nytimes.com/1992/09/01/opinion/l-oregon-health-plan-is-unfair-to-the-disabled-659492.html.

- ICER does not consider patient cost-sharing or Part D reinsurance and coverage gap discounts in its calculations. Cost-sharing can be used to influence patient treatment decisions, to competitively position plans, and to offset costs.
- ICER reports could have the unintended consequence of setting a price floor for some therapies by compelling manufacturers to set prices below a budget threshold. Drug manufacturers could set the price of a new drug at a level just below the budget threshold instead of a lower price and use ICER reports as justification.

We oppose the aforementioned Title 1 provisions in the House bill and encourage both the House and Senate to explicitly prohibit discrimination whether done overtly by Medicare, or covertly via "comparative effectiveness analysis" or reference to foreign countries' use of QALYs and similar average metrics—within the final drug pricing legislation. These safeguards are necessary to protect the health and well-being of people with disabilities, veterans, and older adults.

SECTION III: WHAT WE WOULD LIKE TO SEE INCLUDED

Expanding Patient Protections within the Benefit Redesign

We appreciate that both the Senate and House proposals work to reduce the financial exposure for Part D patients by eliminating their cost-sharing in the catastrophic phase entirely. As stated previously, individual costs in the catastrophic phase of the Part D benefit can be quite high for enrollees on high-cost specialty medications. The establishment of a hard cap on annual out-of-pocket spending at $2,000 would provide patients currently struggling to pay for their medications with considerable financial help. The House proposal currently has the implementation date for an out-of-pocket cap set at 2022, but we strongly encourage you to have the cap established as soon as possible.

In addition to instituting a hard cap on annual out-of-pocket spending, both the Senate and House proposals would change the Part D benefit design significantly. While we greatly appreciate reinsurance designs that limit the financial exposure of patients, we are concerned that both the Senate and House redesigns have the potential to incentivize Part D plans to erode beneficiary protections in order to be more flexible. As plans have increased financial liability for non-LIS enrollees, there will be an incentive for these plans to limit premium increases by increased use of utilization management tools such as prior authorization and step therapy. While these tools could be used to keep Part D plans' costs from fluctuating, they will create significant barriers for patients to access their prescribed medication. The final package should strengthen the Part D appeals process and other patient protections so that beneficiary access is not reduced under the proposed benefit redesign.

Expanding Medicare Coverage to Include Dental, Vision, and Hearing Services

The Alliance has long been supportive of efforts to expand Medicare coverage to include dental, vision, and hearing services, and has championed such bills as the *Seniors Have Eyes, Ears, and Teeth Act*. However, despite the importance of these services for preserving the independence, social connections, and health of older adults, they are not covered by Medicare.

While some Medicare Advantage plans and Medicaid programs recognize the importance of these services and provide coverage, there are still far too many older adults who need these services and are unable to access them. A 2018 study by the Commonwealth Fund found that 75 percent of Medicare beneficiaries who needed hearing aids did not have any, 70 percent with dental issues that made eating difficult had not seen a dentist in the previous year, and 43 percent of beneficiaries experiencing problems with their vision had not received an eye exam in the previous year.[23] People who do not have access to these essential services are at higher risks for depression, social isolation, and overall higher medical costs. If the final package results in significant savings to the Medicare program, we urge that these savings be reinvested to cover dental, vision, and hearing services for beneficiaries. If after these essential services are provided and there are additional savings, we recommend you consider providing coverage to digital health technologies, such as remote monitoring devices, that help beneficiaries stay healthy and share important data on a regular basis with their healthcare providers.

Sharing Rebates at Point of Sale with Part D Enrollees

In February 2019, the Trump administration proposed a rule that would have eliminated Part D drug manufacturers' rebates to Pharmacy Benefit Managers (PBMs), Medicare Part D plans, and Medicaid managed care organization plans and instead would have allowed drug manufacturers to apply discounts at the point of sale. Further, the proposed rule permitted fixed fee arrangements between drug manufacturers and PBMs. While the rule was withdrawn in July 2019, point of sale rebates remains an important priority to many patient advocacy groups, including the Alliance, as they allow Medicare enrollees to benefit directly from the discounts and rebates provided by manufacturers.

The Alliance supports a requirement that Part D plans share a portion of rebates at the point of sale. This policy would most help patients prescribed expensive medications over an extended period, and thereby improve adherence. The current rebate model negotiated between insurance plans, PBMs, and drug manufacturers does not lower the cost of the drug at the retail pharmacy counter for Part D beneficiaries. Reforming the current rebate rule to allow a point of sale savings to beneficiaries would result in relief for millions of patients at the pharmacy counter.

We are encouraged by a recent proposal in the Senate's *Lower Health Care Costs Act* that would require PBMs to pass on 100 percent of any rebates or discounts to plan sponsors. This model could be combined with a requirement for some rebates to be shared at the point of sale with patients. Under this combined approach there would be less of an incentive for formularies to be designed that drive utilization of highly-rebated treatments and patients would directly benefit from the rebates applied to their drugs.

[23] Willink, Amber. How Medicare Could Provide Dental, Vision, and Hearing Care for Beneficiaries. Commonwealth Fund, 2018, How Medicare Could Provide Dental, Vision, and Hearing Care for Beneficiaries: https://www.commonwealthfund.org/publications/issue-briefs/2018/jan/how-medicare-could-provide-dental-vision-and-hearing-care

CONCLUSION: FINISH THIS IMPORTANT WORK TOGETHER

The Alliance applauds Senate and House leaders for their commitment to lower out-of-pocket prescription drug costs for Part D beneficiaries. Now is the time for a collaborative, bipartisan effort that incorporates select provisions from both the Senate and House proposals, incorporates additional policies, and removes proposals that would unintentionally discriminate against older adults and people with disabilities. If you have questions for our organization, please do not hesitate to contact the Alliance's Public Policy Manager, Ryne Carney, at (202) 688-1242 or rcarney@agingresearch.org.

Thank you for your consideration, and we will be eagerly watching and are available to be a resource to you and your staff as you may need.

Sincerely,

Susan Peschin, MHS
President and CEO