Alliance for Aging Research Recommendations for the *Inflation Reduction Act of 2022*

August 2, 2022

The Alliance for Aging Research urges the Senate to make the following changes to the *Inflation Reduction Act of 2022* to advance seniors' health and economic well-being:

1) **Include an unambiguous ban on the use of the QALY and similar average metrics in federally supported healthcare programs.**
2) **Ensure transparency by preserving the essential role of public input into regulatory decision making.**

Since 2018, the Alliance has consistently urged federal policymakers to reject prescription drug price-setting proposals—including international reference pricing, Most Favored Nation, and direct negotiation—that would authorize Medicare program use of discriminatory cost-effectiveness standards to ration care.

The latest version does not fully incorporate the repeated recommendations of the National Council on Disability (NCD), an independent federal agency. Since 2019, the NCD has repeatedly cautioned against permitting use of discriminatory price-setting methodologies, such as the quality-adjusted life year (QALY) because it would undermine the Affordable Care Act (ACA) and major U.S. disability and civil rights laws. Earlier this year, the NCD's 2022 health equity framework put a finer point on the importance of this and called for a "blanket [legislative] prohibition" on the use of QALYs by "any federal agency." Last fall, more than 130 organizations called on Congress to reject drug proposals that use the QALY methodology or similar value assessment frameworks, stating, "As Medicare is the primary source of health insurance for older adults and people with disabilities, utilizing QALYs or similar metrics in pricing would be particularly harmful to the very groups the program is intended to serve." Additionally, a September 2021 *Morning Consult* poll, commissioned by the Alliance for Aging Research, found that 74% of older adults surveyed on Medicare negotiation were concerned that which medications are covered could be decided based on the 'value' of a patients' life by looking at their medical conditions and age. Though there is anti-discrimination language in the bill, use of QALYs would still ultimately be permitted. Worse still, the legislation prohibits public comment or input on drug negotiation processes, including the criteria used to set prices.

3) **Revise rare disease exceptions to allow more flexibility and ensure the broadest group of patients can receive maximum benefit from approved therapeutics.**

The rare disease therapeutic exceptions in the bill unfortunately disincentivize exploring whether an already-developed drug may have clinical benefit for additional conditions. Currently, the bill exempts drugs focused on a single FDA-approved indication from being subject to negotiation. However, this protection is eliminated if the drug is approved for multiple indications or for other types of disease.

4) Restore reductions in patient's coinsurance liability

The most recent version of the reconciliation package proposes to allow Part D premiums to increase by a maximum of 6% annually instead of 4% and require patients to shoulder 25% of the cost of their medications rather than 23%, representing a reversal from the previous iteration of the bill. Congress should strive to reduce total Part D costs for beneficiaries to the greatest extent possible.

5) Include needed protections to ensure patients are able to access "cost smoothing"

The legislation fails to include important protections to ensure patients can access zero-interest payment installments for prescription drugs - known as cost-smoothing - when they need it. Congress should work to ensure than the final version of the bill includes language that prohibits health plans from aggressively preventing patients from utilizing the cost smoothing flexibility.

6) Restore pharmacy benefit manager rebate and transparency reforms

The Alliance supports reforms to ensure that patients benefit from rebates negotiated by pharmacy benefit managers (PBMs), as well as policies that would base beneficiary's coinsurance on negotiated amounts rather than list prices. Unfortunately, this legislation repeals the "rebate rule" that would have forced supply chain middlemen—who retain more than half of all spending on pharmaceuticals—to use the discounts received from drug companies to reduce patients' coinsurance. Requiring pharmacy benefit managers (PBMs) to disclose their discounts and share savings could have saved patients billions.

As Congress makes these changes, the Alliance for Aging Research urges Congress to make every effort to maintain the following provisions in the final bill:

A) Creation of an annual out-of-pocket cap/limit on beneficiary liability

The Alliance applauds Congress for its commitment to addressing out-of-pocket costs (OOP) for Part D beneficiaries. The annual maximum limit on individual's OOP drug costs and the introduction of a cost smoothing flexibility to allow beneficiaries to spread out their expenses over time will help address affordability, access, and equity concerns.

B) Reducing financial barriers to preventative vaccinations

The legislation includes important provisions that address the substantial beneficiary cost sharing for vaccines covered by Medicare Part D. Additionally, all Medicaid beneficiaries – not just those in expansion states, as under current law – would be provided no-cost access to CDC-recommended vaccines. Addressing the financial barriers to vaccination will improve health and lower long-term costs to the Medicare and Medicaid programs.

C) Expansion of the Part D low-income subsidy program

The Alliance supports the inclusion of proposed expansion of the Part D low-income subsidy, or LIS, program. Also referred to as the Medicare Part D Extra Help program, LIS 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. The provision to increase the eligibility thresholds for the LIS program from 135% to 150% will help many older adults who are in financially vulnerable situations but do not currently qualify for the program.

D) Ensuring costs do not increase beyond the rate of inflation

The legislation includes a proposal to require manufacturers to pay a rebate to the Treasury Department if they raise the prices of a Medicare B or Part D drug above the rate of inflation. The Congressional Budget Office estimated the House-passed version of the inflationary cap would reduce beneficiary spending in cost-sharing and premiums by $10 billion over a 10-year period. 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. A similar policy has been in place for over 30 years in the Medicaid program.

For more information, please contact Michael Ward, Vice President of Public Policy and Government Relations, at mward@agingresearch.org.