

August 9, 2012

The Honorable Kathleen Sebelius

Secretary

U.S. Department of Health and Human Services

200 Independence Avenue, S.W.

Washington, DC 20201

Dear Secretary Sebelius:

As the Department moves forward to issue a Notice of Proposed Rulemaking (NPRM) on Essential Health Benefits (EHB) for state-based insurance exchanges under the Affordable Care Act, we would like to bring to your attention an important issue related to prescription drug coverage. In particular, we would like to recommend that the Department at minimum adopt a structure similar to that of the Medicare Part D program in offering access to “all or substantially all” medications in six therapeutic classes affecting conditions such as cancer, HIV/AIDS, kidney disease, mental illness and epilepsy.

You may be aware that the Pharmaceutical Care Management Association (PCMA) – the trade association of the pharmacy benefit management (PBM) industry – recently issued a press statement on their own limited survey alleging that giving patients access to multiple drugs in these six categories will increase health costs by billions of dollars without achieving a corresponding improvement in patient health or access to care. Of course, that allegation must come with the understanding that the purpose of PBMs is to increase profits by denying patients access to medicine.

As millions of patients and patient advocacy organizations that supported the Affordable Care Act and Medicare program over the years know, the linkage between pharmaceutical access and escalating costs are simply incorrect. The truth, in fact, is just the opposite.

Regardless of PBM motivation, though, the salient fact is that charges of linkage between pharmaceutical access and escalating costs are simply incorrect. The truth, in fact, is just the opposite. Providing patients who have critical, life-threatening conditions with access to the drugs they need

actually constrains health care costs by improving patient health and reducing the need for hospitalizations, acute care and emergency care. And, contrary to PBM allegations, the Medicare Part D program is a prime example of this approach's cost-saving success.

Let's separate baseless charges from the hard facts that affect millions of lives:

**1) There are compelling health and economic reasons to provide access to "all or substantially all" pharmaceuticals in these six therapeutic classes.**

Medications do not affect each of us the same way. A particular drug that prevents debilitating epileptic seizures for one patient may cause painful side effects in another. Some patients, frequently those with HIV/AIDS, require medication "cocktails" involving three or more drugs. There are serious ramifications to sharply restricting drug coverage to people with serious health conditions. In fact, this restrictive approach is penny-wise but pound-foolish. PBMs are concerned exclusively with drug costs, but you have to focus on overall health care expenses. When patient access to essential drugs is limited, health symptoms worsen and the system sees increased costs through inpatient hospital days and more ER visits. This is widely documented. The American Psychiatric Institute has found, for example, that Medicaid patients with medication access problem have 74% more emergency room visits and 72% more acute inpatient days.

By contrast, a study by Harvard researchers found that access to needed medications provided by the Medicare Part D program saves about \$1,200 per year per patient in reduced need for hospitalization and skilled nursing facilities.

**2) The Center for Medicare and Medicaid Services (CMS) has stated unequivocally that there will be no cost impact at all if broader drug access is limited to the six protected therapeutic classes.**

This goes straight to the heart of PBM allegations of increased costs through sufficient medication access to Americans with severe health conditions. CMS has flatly stated that is not the case. In fact, in the Medicare Part D program, there has been access to "all or substantially all" medications in these six classes since 2006. This policy has been successful, and has had strong support from both Congress and CMS, because it has saved taxpayer dollars while protecting the health of our most vulnerable citizens. It is essential, in terms of both economic sense and to protect the well-being of millions of patients, to include these same anti-discriminatory policies in the shaping of Essential Health Benefits.

**3) It's simply inaccurate to say that pharmaceutical access has driven up costs in the Medicare Part D program.**

The facts here are clear and indisputable. According to the Congressional Budget Office, expenditures in the Medicare Part D program are 41 percent lower than CBO's initial 10-year projections for the program. And current average Part D monthly premiums are 44 percent lower than original projections. These savings are occurring while medication access for patients with serious health conditions is protected.

That's because there are already mechanisms in place to control costs. PBMs and health insurance companies use formularies, tiered co-payments, prior authorizations and increased incentives to use generic medications to rein in costs. There simply is no need to further restrict access to medicines for vulnerable patients, but there would be severe harm to patient health and increased overall health care expenditures.

What do these facts lead us to conclude? It's clear that the charges emanating from the PBM industry are simply smokescreens designed to increase revenues by denying patients access to the medicines they need. In actuality, providing necessary access to medication for patients with cancer, HIV/AIDS, epilepsy and other critical conditions is both humane and cost-effective, and it should be the approach used in designing Essential Health Benefits that are covered under the Affordable Care Act.

Thank you for your attention in addressing this important issue.

AIDS Foundation of Chicago

The AIDS Institute

AIDS United

American Academy of Neurology

American Autoimmune Related Diseases Association

American Epilepsy Society

American Psychiatric Association

Community Access National Network (CANN)

Epilepsy Foundation of America

Health HIV

HIV Medicine Association

National Alliance of State & Territorial AIDS Directors (NASTAD)

National Alliance on Mental Illness

National Association of People With AIDS

National Council for Community Behavioral Healthcare

National Kidney Foundation

National Minority Quality Forum

San Francisco AIDS Foundation