



June 6, 2019

The Honorable Richard Neal  
Chairman  
House Ways and Means Committee

The Honorable Kevin Brady  
Ranking Member  
House Ways and Means Committee

The Honorable Frank Pallone  
Chairman  
House Energy and Commerce Committee

The Honorable Greg Walden  
Ranking Member  
House Energy and Commerce Committee

**Re: Request for comments on Medicare Part D reforms**

Dear Chairman Neal, Chairman Pallone, Ranking Member Brady, and Ranking Member Walden:

The National Council on Aging (NCOA) appreciates the opportunity to comment on the draft legislation and questions from the House Ways and Means and Energy and Commerce Committees. The National Council on Aging (NCOA) is one of the nation’s leading nonprofit service and advocacy organization representing older adults and the community organizations that serve them. Our goal is to improve the health and economic security of 10 million older adults by 2020. Our recommendations focus primarily on making prescription drugs more affordable for Medicare beneficiaries who struggle the most with these costs and protecting access to needed prescription drugs. Primary issues covered are:

- Part D Out-of-Pocket Cap and Proposed Draft Legislation
- Extra Help Low Income Subsidy (LIS)
- Appeals and Exceptions
- Pricing stability

**Part D Out-of-Pocket Cap and Proposed Draft Legislation**

NCOA supports the establishment of an out-of-pocket (OOP) cap for Medicare beneficiaries in Part D. Currently, beneficiaries must pay 5% of their drug costs indefinitely when they exceed the current out-of-pocket threshold \$5,1000. A hard cap would reduce out-of-pocket costs and enhance predictability for the approximately 1 million beneficiaries who reach the catastrophic phase (in 2015) and do not have low-income-subsidies. These beneficiaries incurred over \$3,000 in OOP costs on average, with 10% of them spending at least \$5,200. In total, these beneficiaries spent \$1.2 billion in out-of-pocket costs above the threshold, or \$1,215 per person in 2015.<sup>1</sup> Research also shows that mean out-of-pocket costs have increased significantly in the catastrophic phase – thus, an OOP maximum is a critical avenue to lower OOP costs for beneficiaries.<sup>2</sup>

We understand that an OOP cap could lead to a small increase in premiums for Part D enrollees. While we do not want beneficiaries’ out-of-pocket costs to increase overall, a small increase in premiums would be

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<sup>1</sup> Cubanski et al. *No Limit: Medicare Part D Enrollees Exposed to High Out-of-Pocket Drug Cost Without a Hard Cap on Spending*. Kaiser Family Foundation Issue Brief. November 2017. <http://files.kff.org/attachment/Issue-Brief-No-Limit-Medicare-Part-D-Enrollees-Exposed-to-High-Out-of-Pocket-Drug-Costs-Without-a-Hard-Cap-on-Spending>

<sup>2</sup> Trish, E., Xu, J. and Joyce, G. 2016. *Medicare beneficiaries face growing out-of-pocket burden for specialty drugs while in catastrophic coverage phase*. Health Affairs. Available at [https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.0418?url\\_ver=Z39.88-2003&rfr\\_id=ori%3Arid%3Acrossref.org&rfr\\_dat=cr\\_pub%3Dpubmed](https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.0418?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed)

acceptable if, on the whole, average OOP costs decrease, particularly for those with the greatest needs and highest expenses.

Congress should consider a few factors when creating an OOP cap. For example, the draft legislation pegs the OOP cap to the current catastrophic threshold. If the cap is set at too high of a threshold, fewer beneficiaries will hit the threshold and experience the relief from limiting their out of pocket expenses. We are very concerned that the draft fails to address the impending “cliff,” when the catastrophic threshold will increase significantly by \$1,250, from \$5,100 to \$6,350. We strongly recommend that the draft legislation be amended to fix this cliff, indexing the threshold at the same rates as previous years. Last July, NCOA supported H.R. 6563, the Lower Out-of-Pocket Costs for Seniors Act, introduced by Chairmen Neal and Pallone. We recommend that a similar approach be taken this year.

We also encourage Congress to consider options for spreading out-of-pocket costs over the year so that beneficiaries do not incur unaffordable costs for the first few months before they reach the threshold. This is particularly difficult for older adults that are on a fixed monthly income. For certain diseases, the first bill of the year may equal or exceed the average monthly Social Security benefit.<sup>3</sup> Congress should consider how to make a monthly or quarterly OOP cap work, rather than an annual cap. Some form of retroactive adjustments to smooth the burden throughout the year might also be considered.

When considering the appropriate liability for each payer, we encourage Congress to ensure that both prescription drug plans and drug manufacturers have some liability and skin in the game for each phase of the Part D benefit so that equitable, balanced incentives are structured to control costs. Ensuring that each of these parties has liability in each part of the benefit will address the potential for unintended consequences even as Congress works to create a Part D structure with fewer incentives for high prices.

Some proposals to restructure the Part D benefit suggest that, in addition to changing the reinsurance liabilities above the catastrophic threshold and establish an OOP cap, manufacturer coverage gap discounts should no longer count towards true out-of-pocket costs (TrOOP). NCOA strongly opposes excluding manufacturer discounts from TrOOP costs. Even when combined with an OOP cap, the policy would increase OOP costs for many beneficiaries by keeping them in the coverage gap longer. Our hope is that Congress will pursue reforms that will make prescription drugs more affordable for Medicare beneficiaries, not less.

An Avalere analysis of this policy in 2016 found that excluding manufacturer coverage gap discounts from TrOOP costs would increase OOP costs for beneficiaries who have high enough drug spending to approach or reach the catastrophic portion of the benefit.<sup>4</sup> On average, 1.1 million Part D enrollees would experience higher OOP costs each year between 2017 and 2021. Total Part D beneficiary spending would increase by about \$5.1 billion over the same period. OOP spending for each affected beneficiary would increase by an average of almost \$1,000 per year throughout the 5-year period.

According to MedPAC, about half of beneficiaries who currently reach the catastrophic threshold would not reach this level if manufacturer discounts are eliminated from the coverage gap.<sup>5</sup> Additionally, this

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<sup>3</sup> <https://www.ajmc.com/journals/supplement/2017/beyond-charitable-assistance-sustainable-strategies-for-providing-access-to-critical-medications/reducing-out-of-pocket-cost-barriers-to-specialty-drug-use-under-medicare-part-d?p=2>

<sup>4</sup> Frieder, M. 2016. Proposed changes to Part D would increase beneficiary costs. Avalere. Available at <http://avalere.com/expertise/managed-care/insights/proposed-changes-to-part-d-would-increase-beneficiary-costs>.

<sup>5</sup> MedPAC April 2019 <http://medpac.gov/-public-meetings->.

would exacerbate problems that come from frontloading costs if the OOP cap is annual, rather than monthly or quarterly.<sup>6</sup> This would impact the beneficiaries who already face the highest drug costs, and increase their burden rather than decrease it, which should be a primary goal of any enacted proposal.

During MedPAC's April 2019 meeting, commissioners discussed the possibility of still having some beneficiary liability above an OOP cap, in the form of a copayment. We oppose including beneficiary liability above an OOP cap. By the time beneficiaries reach this cap, they have already paid a significant amount and are often in a treatment pattern for high-cost specialty drugs. Such a copayment would only serve to penalize these beneficiaries, rather than positively impact their utilization patterns. Recent analyses show that LIS beneficiaries, despite having substantially less cost-sharing, do not overutilize specialty drugs at a greater rate than the non-LIS population.<sup>7</sup>

Congress must also consider the potential impact of an OOP cap, reinsurance changes, or other potential Part D changes in light of recent and anticipated administrative changes to Part D. Interactions between different policy changes to the system could either exacerbate negative impacts, or lead to minimal improvements in rising OOP costs, if one policy change offsets another that is implemented. For example, Congress should consider how potential changes to the use of manufacturer rebates in Part D combined with an OOP cap might impact prescription drug pricing.

### **Extra Help Low Income Subsidy (LIS)**

Making prescription drugs more affordable for low-income Medicare beneficiaries should be a priority. The Part D Extra Help Low-Income Subsidy (LIS) was designed to address the needs of this particularly vulnerable population, but the program has significant flaws that should be addressed. Policymakers should consider reinvesting savings secured through restructuring of the Part D benefit to promote access and affordability among the lowest income beneficiaries.

It is important to note that the share of LIS enrollees in Part D has declined over time, from 42% in 2006 to 28% in 2019. Additionally, annual LIS enrollment growth (2.4% from 2006-2019) has lagged behind overall Part D enrollment (5.7% during the same period).<sup>8</sup>

Foremost among the program's flaws is the unduly restrictive asset test that penalizes low-income beneficiaries who did the right thing during their working years by setting aside a modest nest egg of savings to use in case of emergencies. It is important to note that low-income older adults in Medicaid expansion states receive significant help with their costs regardless of assets – assistance they may lose when they turn 65. We strongly support Sen. Casey's S.691 - Medicare Extra Rx HELP Act of 2019, which would eliminate the asset test and strengthen income eligibility provisions. Alternatively, we support raising the asset eligibility thresholds to \$75,000 for an individual, which is the approximate midpoint of the Medicaid spousal impoverishment minimum (\$25,284) and maximum (\$126,420) resource standards, and \$125,000 for a couple.

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<sup>6</sup> <https://www.ajmc.com/journals/supplement/2017/beyond-charitable-assistance-sustainable-strategies-for-providing-access-to-critical-medications/reducing-out-of-pocket-cost-barriers-to-specialty-drug-use-under-medicare-part-d?p=2>

<sup>7</sup> MedPAC. April 2019 meeting

<sup>8</sup> Cubanski J, Damico A, and Neuman T. *10 Things to Know about Medicare Part D Coverage and Costs in 2019*. Kaiser Family Foundation. June 2019 Data Note. <http://files.kff.org/attachment/Data-Note-10-Things-to-Know-about-Medicare-Part-D-Coverage-and-Costs-in-2019>

Another approach that merits consideration is allowing beneficiaries to qualify for LIS through the absence of investment income, as an alternative to the asset test. Administering the asset test consumes substantial administrative resources. States that have eliminated the asset test for Medicare Savings Programs (MSPs) have reported substantial savings. For those who would like some measure of beneficiaries' assets, examining investment income may be a good alternative, while simplifying the program requirements and producing administrative savings. Investment income is often an indicator of ownership of assets. Precedence for this approach has been set in the eligibility requirements for the Earned Income Tax Credit. When simulating this approach to MSPs, a recent study found that 78% of older adults eligible for MSPs receive no investment income, and could qualify without undergoing an asset test. The same study found that eligibility for MSPs would increase 30% in this scenario.<sup>9</sup>

Another alternative is to not count funds in retirement savings plans such as 401(k) accounts as assets, but do count distributions from such plans as income.<sup>10</sup> For the majority of people who are not covered by traditional defined benefit pension plans, the resources in their 401(k) and other retirement savings accounts represent their only retirement savings. Periodic distributions during retirement from 401(k) accounts often constitute the only income people have to supplement their Social Security benefits. However, Social Security does not consider a person's pension (defined benefit plan) to be an asset when determining LIS eligibility. Pensions are only counted as income to the extent that a person is actually drawing money from them. Forcing people to cash in their 401(k) plans to become eligible for LIS is a disincentive for people to save for retirement and impacts their economic security for the rest of their lives. As with traditional pension plans, distributions from 401(k) plans should be treated as income, but the funds in the account should not be treated as assets. Treating the two retirement vehicles differently is inconsistent and unfair to people whose primary planned retirement source is a 401(k).

Consideration should also be given to eliminating the partial LIS benefit. Only the lowest income people with Medicare receive full benefits through Extra Help, including zero premiums and fixed copayments. Whereas, individuals with incomes of about \$16,800 to \$18,700 who also meet the program's asset test are exposed to premiums, deductibles as well as high coinsurance rates (15%). Preliminary research findings suggest Extra Help enrollees with partial benefits are less likely to adhere to prescribed treatment protocols than those with full Extra Help benefits or with no Extra Help benefits at all. This proposal would significantly lessen administrative burden by eliminating the premium scale and differentiation in the benefit. This proposal would also enhance benefits and affordability for the LIS population.

We are also hopeful that other more modest LIS improvements be considered:

- 1. Eliminate Cost Sharing for Generic Drugs.** NCOA strongly supports the elimination of cost sharing on generic drugs for LIS enrollees. This would encourage beneficiaries to utilize lower priced drugs, in addition to lowering out-of-pocket-costs for these vulnerable beneficiaries. In 2013, the generic dispensing rate was 81% for LIS enrollees and 84% for non-LIS enrollees. A December 2015 CMS analysis found that "Generic Substitution Rates (GSRs) for generic-tier \$0 copay plans were higher than in non-\$0 copay plans...for both LIS and non-LIS populations."<sup>11</sup> Relative to non-LIS

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<sup>9</sup> Dorn S. and Shang B. 2012. Spurring enrollment in Medicare savings programs through a substitute for the asset test focused on investment income. Health Affairs. Available at <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0443>.

<sup>10</sup> See Sec. 4 of Sen. Bingaman's bill S. 1185, the Medicare Financial Stability of Beneficiaries Act, introduced in June of 2009.

<sup>11</sup> Centers for Medicare and Medicaid Services. December 2015. *Does enrollment in generic-tier zero-copay plans improve generic use within the Part D program?* <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Does-Enrollment-in-Generic-Tier-Zero-Copay-Plans-Improve-Generic-Use.pdf>

populations, LIS enrollees are in poorer health and often have multiple conditions or diseases. Due to these complexities, they tend to fill more prescriptions than non-LIS beneficiaries.

Some previous proposals to introduce a zero copay for generic drugs for LIS beneficiaries also suggest a proposal to increase the copays for brand drugs for this same population. While we are supportive of a \$0 copay for generics, we oppose increasing the copays for brand drugs. Cost sharing alone is not the sole factor contributing to disproportionate use of brand name drugs by Extra Help beneficiaries. Differences in health status, prescriber behavior and pharmacy incentives all contribute to beneficiaries' use of generics or brand drugs. Multiple studies suggest increased cost sharing deters access not just for unneeded health care services and medicines, but also to those that are necessary; these effects are most acute for beneficiaries with the lowest incomes. In the long run, reductions in the use of medically necessary care can, in fact, increase health care spending through the increased likelihood of emergency room visits, ambulance rides and hospital stays.

**2. Index the copayments and deductibles for LIS enrollees with incomes below 150% of the Federal Poverty Level (FPL) to the Social Security Cost of Living Adjustment (COLA).**

Alternatively, index copayments and deductibles for enrollees between 100-150% of the FPL to the Consumer Price Index (CPI), as was proposed in Rep. Doggett's 2007 bill H.R. 1536.<sup>12</sup> Under current law, LIS enrollees with incomes below 100 percent of the FPL have their prescription drug cost sharing increased according to the CPI (all items, U.S. city average). However, for LIS enrollees with incomes between 100 and 150 percent of poverty, their cost sharing is increased according to the percentage increase in average per capita aggregate expenditures for covered Part D drugs. The Social Security COLA is the most accurate reflection of annual income increases for these fixed-income populations and is therefore likely the best index to use for each of these groups. The current indexing methodology for the 100-150% FPL group is particularly problematic since it increases out-of-pocket costs at a potentially much higher rate than increases in ability to pay, and could significantly erode the value of the LIS benefit over time. Alternatively, the copayments and deductibles for people with incomes between 100-150% of FPL could be indexed to the CPI to align with the methodology for enrollees with incomes below 100% of FPL, and better ensure that low-income beneficiaries can continue to afford their prescription drugs.

**3. Examine feasible alternatives to current LIS assignment.** NCOA is concerned about the rate of reassignment and subsequent involuntary plan-switching LIS enrollees' experience, as well as whether they are assigned to plans that meet their needs. Every year, CMS re-calculates the benchmark for each region, often causing significant fluctuations as some plans lose benchmark status. Unless LIS enrollees at any time in the past chose their current plan, CMS randomly reassigns them to a new benchmark plan. Low-income beneficiaries are forced to change plans more frequently than non-LIS enrollees. For example, between 2006 and 2010, 7 out of 10 LIS enrollees experienced one or more plan changes, compared to 3 out of 10 non-LIS enrollees.<sup>13</sup> This kind of churning contributes to instability and uncertainty for vulnerable LIS enrollees, as well as for health plans. Other thoughts on how to reduce this churning would be appreciated.

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<sup>12</sup> See Sec. 4 of H.R. 1536, Rep. Doggett's Prescription Coverage Now Act – H.R. 1536, introduced 3/15/07 (<https://www.congress.gov/bill/110th-congress/house-bill/1536/text?q=%7B%22search%22%3A%22prescription+coverage%22%7D&r=3&s=2#toc-HD840960D7DD04551A34B294F4274C98C>)

<sup>13</sup> See Figure 9 in Hoadley, Summer, et al. *To Switch or Be Switched: Examining Changes in Drug Plan Enrollment among Part D Low-Income Subsidy Enrollees*. Kaiser Family Foundation (July 2015)

There are currently 215 benchmark plans available, which is the lowest number of benchmark plans beneficiaries have been able to access since Part D started (in 2007 there were 640 benchmark plans and in 2010 there were 307). The number of available benchmark plans varies widely by region. Although on average beneficiaries can choose from 6 benchmark plans, availability by state ranges from only 2 benchmark plans in Florida to 10 benchmark plans in Arizona. It is also important to bear in mind that, although all benchmark plans have a zero premium for LIS enrollees, differences in their formularies and benefit designs can lead to considerable differences in out-of-pocket costs, especially when their drugs are excluded from a plan's formulary.

In order to ensure that LIS enrollees are given sufficient choices among affordable plans, they should be given the ability to be reassigned into enhanced plans. According to a September 2010 Kaiser Family Foundation report:

*Enhanced plans, which are supposed to have a greater actuarial value than basic plans, have never been included among the group of plans to which LIS beneficiaries can be reassigned. But for some beneficiaries they may be a logical alternative. Distinctions between basic and enhanced plans have become less clear as the Part D program has evolved. In 2010, for example, 136 basic plans had higher monthly premiums than the enhanced plans offered by the same sponsor in the same region. LIS beneficiaries enrolled in enhanced plans, even in the 93 enhanced plans with premiums below the benchmark in 2010, must pay premiums to cover the enhanced portion of the plan. Yet, the total premium for a low-premium enhanced plan may be below benchmark. The government would save money on premiums if LIS beneficiaries were assigned to those plans even if it paid the enhanced portion of the premium.<sup>14</sup>*

Additionally, rather than random assignment, a wide array of experts believe that assigning LIS enrollees based on their individual prescription drug needs would reduce their out-of-pocket costs and Medicare spending. Over the years, various proposals have been made to replace random assignment with “intelligent” or “beneficiary-centered” assignment. For example, in 2007, the House passed Rep. Dingell’s CHAMP Act legislation (H.R. 3162), which included a provision on intelligent assignment that CBO scored at \$1.2 billion in savings over 10 years.<sup>15</sup> Factoring in prior medication use, pharmacy preferences, and cost savings into the assignment process can improve access to needed drugs and save money both for beneficiaries and the Medicare program. According to a June 14, 2104 Health Affairs article: “We used an intelligent assignment algorithm and 2008-09 Part D drug use and spending data to match enrollees to available plans according to their medication needs. We found that such a reassignment approach could have saved the federal government over \$5 billion in 2009, for government savings of \$710 (median: \$368) per enrollee with a low-income subsidy.”<sup>16</sup>

- 4. Empower and improve education for LIS enrollees by sending the Chooser’s Notice to all with premium liability.** The CMS Part D LIS Chooser’s Notice is only sent to LIS enrollees with new or increased premium liability relative to the previous year. NCOA is concerned that many LIS enrollees

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<sup>14</sup> Summer, Hoadley and Hargrave, *The Medicare part D Low-Income Subsidy Program: Experience to Date and Policy Issues for Consideration* (September 2010, <https://www.kff.org/wp-content/uploads/2013/01/8094.pdf>)

<sup>15</sup> See Sec. 218 of Rep. Dingell’s Children’s Health and Medicare Protection (CHAMP) Act – H.R. 3162, passed the House on 8/1/07 (<https://www.congress.gov/bill/110th-congress/house-bill/3162/text?q=%7B%22search%22%3A%22HR+3162%22%7D&r=1&s=1>) and scored by CBO as saving \$1.2 billion over 10 years: <https://www.cbo.gov/sites/default/files/110th-congress-2007-2008/costestimate/hr316200.pdf>)

<sup>16</sup> Zhang, Zhou, and Faik, *A Simple Change to the Medicare Part D Low-Income Subsidy Program Could Save \$5 Billion*. Health Affairs 33:6 June 2014)

in a non-benchmark (not zero premium) plan that will have the same or reduced premium compared to the previous year, do not receive the Chooser's Notice – regardless of how high their new premium would be. We agree with the concern expressed by CMS in their 2011 draft Call Letter that choosers in non-benchmark plans may not fully understand that they have less expensive alternatives.

In 2019, this group, representing about 10% of LIS enrollees pays an average of about \$24 a month in premiums because they are not enrolled in available zero premium plans<sup>17</sup>. For LIS enrollees, \$288 per year can be a significant burden. In 2017, 225 LIS enrollees in the BlueMedicareRx-Option 2 plan had a \$142.90 monthly premium (\$3.70 lower than in 2016) and 666 LIS enrollees in the Blue Medicare Rx Primer plan had a \$92.90 monthly premium (\$3.60 lower than in 2016). None of these LIS enrollees were eligible to receive a Chooser's Notice. In our view, they should receive the notice and be made aware that they may be able to significantly reduce their out-of-pocket costs if they switched to a zero premium benchmark plan.

All LIS enrollees who have premium liability should receive the Chooser's Notice. CMS already encourages all Part D enrollees to shop during Open Enrollment to see if they could benefit with a different plan, and the Chooser's Notice could strengthen that message for this particular group of enrollees who have a demonstrable opportunity to save money with a switch. Too many low-income beneficiaries are paying premiums unnecessarily, some with substantial out-of-pockets costs, and should receive reminders and information on how to save money by shopping for lower cost Part D plans.

5. **Make all LIS applications and subsequent correspondence from SSA available in at least three additional commonly spoken languages.** Although some LIS-related materials are translated into a variety of languages, application forms are only available in English and Spanish. Additional efforts should be made to find and enroll difficult-to-reach, low-income populations for whom English is not their primary language, and are more likely to have literacy issues. Rep. Doggett's Research by the U.S. Census and others has shown the prevalence of languages other than Spanish. Nearly 2 million adults over the age of 65 speak another Indo-European language, and nearly 2 million older adults speak an Asian/Pacific Island language. The application materials should be made available for at least the three most-requested languages at SSA for Retirement Claims.
6. **Making LI NET Permanent.** We are also supportive of H.R. 3029. The Improving Low Income Access to Prescription Drugs Act, which would make the Limited Income Newly Eligible Transition (LI NET) Program permanent. This program acts as an important safety net for beneficiaries that are eligible for LIS, but are not yet receiving Part D coverage. It allows beneficiaries immediate access to covered part D drugs at the point of sale during the period that begins on the first day of the month a person is determined to be eligible for LIS. The permanent program should maintain its open formulary and open pharmacy network during the short period that these beneficiaries are enrolled in the LI-NET program. Therefore, beneficiaries do not have to experience a lapse in access to their prescription drugs.

### **Appeals and Exceptions**

NCOA has several suggestions for improving the appeals process, which will ensure that beneficiaries retain access or lower out pocket costs for drugs that are necessary for their unique medical needs. The

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<sup>17</sup> Cubanski J, Damico A, and Neuman T. *10 Things to Know about Medicare Part D Coverage and Costs in 2019*. Kaiser Family Foundation. June 2019 Data Note. <http://files.kff.org/attachment/Data-Note-10-Things-to-Know-about-Medicare-Part-D-Coverage-and-Costs-in-2019>

appeals process is an essential safety valve, allowing access to prescription medications that are not on the plan's formulary, or are subject to high cost sharing, when formulary or lower cost alternatives are not appropriate for a beneficiary's unique medical needs. To ensure that Part D enrollees can successfully navigate the appeals process, information at the point of sale should be improved and the appeals process should be streamlined.

We believe that access to information about the reason for a plan denial—provided at the pharmacy counter—will both eliminate significant beneficiary confusion and limit delays in accessing needed medications. Armed with information about why a prescription drug was refused at the pharmacy counter, Part D enrollees and their providers will be better equipped to determine the best course of action for the beneficiary's health. Along these same lines, we strongly support allowing the pharmacy counter refusal to serve as the coverage determination. This proposal serves the dual purpose of removing a burdensome step for beneficiaries and their prescribers, first, by explicitly stating why the drug is not covered and, second, by expediting the appeals process for those who need it. In the interim, we recommend requiring that the existing pharmacy counter notice explain the reason (i.e., prior authorization, step therapy, quantity limits, off-formulary, non-covered, etc.) that the beneficiary is being turned away at the pharmacy counter. This simple, straightforward information would better equip Part D enrollees and their providers to navigate the appropriate next steps, whether by requesting a coverage determination or pursuing an alternative medication.

We note with interest a February 4, 2014 letter to then CMS Administrator Marilyn Tavenner, signed by every member of the Senate Finance Committee, stating in part: “We recommend improving the part D appeals process before any change to drug coverage. For instance, we encourage CMS to explore ways to allow the beneficiary to initiate the appeals process at the pharmacy counter when he/she is first notified the drug is not covered by the part D plan.” It has been over five years since that bipartisan letter was sent. It is time for Congress to take action.

We also strongly support the establishment of a cost-sharing exception and appeal process for drugs included on the specialty tier. Spending on specialty drugs has increased substantially in recent years. In 2017, spending on these drugs reached \$37 billion, or 25% of all of Part D spending. The average claim for these drugs ranges from \$1,500 all the way up to \$31,000.<sup>18</sup> Thus, drugs on the specialty tier represent an enormous out-of-pocket cost burden for beneficiaries. The issue remains exceptionally important for beneficiaries with conditions that have limited treatment options (i.e., when all the therapeutic options fall under the specialty tier and its equivalent higher cost-share for beneficiaries). For all other plan formulary tiers, beneficiaries may file an exception for a drug to be placed on a lower cost-sharing tier, provided that the medication is the only therapy available for their disease. Specialty tier drugs are the sole exception, even though these drugs often have the most burdensome cost-sharing requirements. We encourage Congress to work with CMS on implementing an exception and appeal process for the specialty drug tier at the earliest possible time.

### **Pricing stability**

We are increasingly concerned about reports from surveys of Medicare State Health Insurance Assistance Programs (SHIPs) that Medicare Part D prescription drug out-of-pocket coinsurance costs that beneficiaries see when they shop for a plan during Open Enrollment may increase later in the year at the point of sale. Because list prices can increase sporadically throughout the year, this impacts beneficiary cost sharing for two reasons: first, many beneficiaries must pay a coinsurance, or percentage of the list price, without knowing what the actual cost will be for each fill since the denominator typically is

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<sup>18</sup> MEDPAC April 2019 meeting

unknown. Second, if the list price increases multiple times throughout the year, beneficiaries may move through each coverage phase faster than they predicted.

In our view, a beneficiary who calculates and plans for her drug cost as \$30/fill during Open Enrollment should be able to still pay the same or lower coinsurance amount in April and September. Since beneficiaries are expected to enroll and be locked into a plan for one year, plans should also be expected to keep the prices they charge stable for that year. Unfortunately, we understand that, unrelated to what benefit stage they may be in, beneficiaries too frequently experience an increase in their out-of-pocket coinsurance amount as the drug prices increase throughout the year. As a result, beneficiaries may, for example, owe \$45 per fill in January and \$60 in August.

According to some SHIP directors, when they have filed complaints with CMS, we understand that CMS has simply updated Medicare Plan Finder (MPF) to reflect the change in estimated annual out-of-pocket costs, without addressing or acknowledging that plans are not honoring the prices displayed during open enrollment. Given that beneficiaries already struggle to understand the concept of coinsurance (frequently listed as a range of percentages) as displayed on MPF, the lack of stability in prices makes it even harder for beneficiaries to shop and plan their estimated drug expenses.

In addition to ensuring that MPF is fixed so that actual OOP cost sharing amounts are clear rather than displayed as a range or percentage, we encourage Congress to craft legislation addressing this price stability problem. For example, plans could be required to develop pricing agreements with pharmaceutical companies, which cap the prices for drugs on coinsurance tiers, for at least a year at a time. Beneficiaries should not be subject to surprise increased costs at the pharmacy counter, but should be able to predict and plan for their expenses on a yearly basis as much as possible. Congress could also work with CMS to establish a Special Enrollment Period for individuals adversely affected by a significant change in coinsurance responsibility mid-year.

At a minimum, this issue merits further research. Congress could require a report, in which HHS compares the drug prices and out-of-pocket coinsurance amounts paid during open enrollment with prices and coinsurance amounts incurred at later dates, based on claims data. The objective would be to better understand how frequently the drug prices on coinsurance tiers increase during the year, how much they increase, and whether there are any particular points in time when prices are higher than during open enrollment. An analysis might also consider:

- Are there specific prescription drug plans that lack pricing stability for drugs on coinsurance tiers (defined as differences between prices displayed at open enrollment and those incurred during the benefit year) more than others, regardless of the drug?
- Are there specific drugs that particularly lack pricing and coinsurance stability more than others, regardless of the plan? Is there a different trend for generics versus brands? Does price instability occur more for certain drug classes? Do the price and coinsurance variations occur for all pharmacies, or is there variation by pharmacy?

Thank you again for this opportunity to share our comments. If you have any questions or if we can be of any further assistance, please contact me at [howard.bedlin@ncoa.org](mailto:howard.bedlin@ncoa.org).

Sincerely,

Howard Bedlin  
Vice President, Public Policy and Advocacy