



Statement for the Record

Submitted to the
Senate Committee on Finance

On behalf of the Medicare Rights Center
Regarding the July 25, 2019
“Open Executive Session to Consider an Original Bill
Entitled the Prescription Drug Pricing Reduction Act of 2019”

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Chairman Grassley, Ranking Member Wyden, and distinguished Members of the Senate Committee on Finance, on behalf of the Medicare Rights Center (Medicare Rights), thank you for your bipartisan efforts to address the problem of high and rising prescription drug prices, and for the opportunity to share our perspective on this important issue.

Medicare Rights is a national, non-profit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. We provide services and resources to nearly three million people with Medicare, family caregivers, and health care professionals each year.

Based on this experience, we know that prescription drug affordability and access is an ongoing challenge. Every day on our National Consumer Helpline, we hear from older adults and people with disabilities who are struggling to obtain needed medications. Given that many people with Medicare live on fixed or limited incomes that cannot keep pace with high and rising drug prices, the perennial nature of these calls is alarming, but not surprising.

Currently, half of all Medicare beneficiaries—nearly 30 million older adults and people with disabilities—live on \$26,200 or less per year, while one quarter have incomes below \$15,250 and less than \$14,550 in savings.¹ At the same time, health care costs are taking up a larger and more disproportionate share of beneficiaries' limited budgets. In 2016, nearly 30% of Medicare households spent 20% or more of their income on health care, while only 6% of non-Medicare households did so.² Out-of-pocket costs for prescription drugs represent a significant share of this amount, accounting for nearly one out of every five beneficiary health care dollars.³

With health-related expenses projected to consume a greater share of beneficiaries' income over time, if left unaddressed these affordability challenges will only worsen.⁴ Already, it is not just lower-income beneficiaries who are affected by increases in prescription drug prices. In 2017, over 40% of Medicare Rights' Helpline callers who were screened for Part D assistance programs such as Extra Help did not qualify due to having income and assets in excess of the program's eligibility thresholds.⁵ As the population ages and prices continue to rise, we are concerned that an ever-growing number of beneficiaries will find the cost of prescriptions, help paying these costs—or both—to be out of reach.

Immediate action is needed to reform the current drug pricing system in ways that will protect and strengthen the health and economic security of current and future Medicare beneficiaries. We applaud your bipartisan efforts to achieve these goals, including the Prescription Drug Pricing Reduction Act of 2019. The considered package contains a number of significant changes that we are pleased to support—such as a redesign of the Part D benefit that caps out-of-pocket costs for Medicare beneficiaries; the imposition of inflationary rebates on certain drugs in Parts B and D; language making

¹ Jacobson, Gretchen et al., Kaiser Family Foundation. "Income and Assets of Medicare Beneficiaries, 2016-2035," (April 21, 2017), available at: <https://www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2016-2035/>.

² Cubanski, Juliette et al., Kaiser Family Foundation. "The Financial Burden on Health Care Spending: Larger for Medicare Households than for Non-Medicare Households," (March 1, 2018), available at: <https://www.kff.org/medicare/issue-brief/the-financial-burden-of-health-care-spending-larger-for-medicare-households-than-for-non-medicare-households/>.

³ Kaiser Family Foundation. "10 Essential Facts about Medicare and Prescription Drug Spending," (January 29, 2019), available at: <https://www.kff.org/infographic/10-essential-facts-about-medicare-and-prescription-drug-spending/>.

⁴ Cubanski, Juliette et al., Kaiser Family Foundation, "Medicare Beneficiaries Out-of-Pocket Health Care Spending a Share of Income Now and Projections for the Future," (January 26, 2018) available at: <https://www.kff.org/report-section/medicare-beneficiaries-out-of-pocket-health-care-spending-as-a-share-of-income-now-and-projections-for-the-future-report/>.

⁵ Riccardi, Fred et al., Medicare Rights Center, "Medicare Trends and Recommendations: An Analysis of 2017 Call Data from the Medicare Rights Center's National Helpline," (April 2019) available at: <https://www.medicarerights.org/pdf/2017-helpline-trends-report.pdf>.

the Limited Income Newly Eligible Transition (LI NET) Program permanent; and reforms to better align pricing incentives, increase drug pricing transparency, and reduce drug waste.

As you finalize this legislation, we urge you to further improve beneficiary access and affordability by including the following updates to the Medicare Part D appeals process and low-income programs:

The Streamlining Part D Appeals Process Act

The Part D appeals process is an essential safety valve that allows older adults and people with disabilities to access and afford needed prescriptions. However, complexities in the current system can make it difficult for beneficiaries to obtain the relief they need.

On Medicare Rights' National Consumer Helpline, we frequently hear from Part D enrollees who are struggling with appeals and coverage-related issues. Many of these callers were told at the pharmacy counter that their plan would not cover their medication—but not the reason why.

Pharmacists do not tend to have details about the coverage decision and can only direct enrollees to contact their plan for an explanation. As a result, affected enrollees may have no choice but to leave the pharmacy without their medication or a clear understanding of why it was denied. Confused about what to do next, some may bypass the appeals process, returning later to pay what they can out-of-pocket, or decide to forego the medication altogether.

Those who do take action must embark on a tedious fact-finding mission. This includes calling their plan to learn why the medication was refused—because of a formulary or coverage restriction, for example—and working with their physician to determine the best path forward, such as trying an alternative drug or appealing for coverage of the medication as prescribed.

Beneficiaries who decide to appeal must then re-engage with their plan to obtain a written denial that explains the plan's reason for non-coverage—even though the plan has already issued a denial at the pharmacy counter, and even though the beneficiary has already contacted their plan to learn why. Only upon receipt of this "official" notice, known as a coverage determination, may a beneficiary request a formal appeal.

This process is overly onerous and deeply flawed. Beneficiaries can find it difficult to manage these multiple—and often duplicative—phases of coordination and consultation, each of which requires many phone calls, long wait times, and significant persistence. At the same time, adhering to these complicated rules can also create administrative burdens for plans, pharmacists, and providers. Together, these inefficiencies can lead to delays in beneficiary access to needed prescriptions, abandonment of medications, reduced adherence to treatment protocols, worse health outcomes, and higher costs.

The bipartisan, bicameral Streamlining Part D Appeals Process Act (S. 1861/H.R. 3924) championed by Senators Cardin (D-MD) and Cornyn (R-TX) would meaningfully address these challenges. By allowing a refusal at the pharmacy counter to function as the plan's initial coverage determination, this bill would:

- Trigger the provision of a detailed, formal denial notice at the point-of-sale, giving people with Medicare more timely access to actionable information about their plan's coverage decision; and

- Eliminate unnecessary steps within the current system—including the need for beneficiaries to request pre-coverage determination information and counsel from their plans and providers—thereby empowering beneficiaries to more expeditiously exercise their appeal rights and obtain an independent review.

These improvements would help ensure people with Medicare can better access, understand, and manage the Part D appeals process—now and in the future.

Notably, the Committee has long-supported this policy change. A February 4, 2014 letter to Centers for Medicare & Medicaid Services (CMS) Administrator Marilyn Tavenner—signed by every member of the Senate Finance Committee—states, in part: “We recommend improving the Part D appeals process . . . 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.”⁶ We urge you to address this documented need without further delay by adding the Streamlining Part D Appeals Process Act to the final drug pricing package.

Medicare Part D Low Income Programs

The Part D Low-Income Subsidy (LIS), or Extra Help, was designed to address the needs of low-income Medicare beneficiaries, but the program has significant flaws that should be addressed. We encourage you to consider incorporating the following reforms:

Eliminate the Asset Test & Expand Eligibility for LIS. We support eliminating the asset test and extending the standard LIS benefit to all people under 200% of the federal poverty limit, as outlined in the Medicare Extra Rx HELP Act (S. 691). We also support interim steps to lessen the burden of the asset test, such as treating retirement savings accounts in the same manner as pensions are currently—with distributions counting as income but discounting the savings from assets.

Eliminate Cost-Sharing on Generics for LIS Beneficiaries. We also recommend eliminating cost sharing on generics for LIS beneficiaries. Even a minimal amount of cost sharing can be a barrier to access. While some plans do offer \$0 copay for some generics, applying this policy consistently to all generics would more effectively reduce financial burdens for low-income beneficiaries and increase medication adherence. Encouraging the use of generics should never come at a cost of limiting access to the full range of medications, however. It is important that reducing generic copays to \$0 not be accompanied by an increase in LIS cost sharing for branded drugs.

Notify All LIS Enrollees Who Have Premium Liability about \$0 Premium Plans. Currently, CMS sends the LIS “Chooser’s Notice” only to LIS enrollees with new or increased premium liability relative to the previous year. We are concerned that many LIS enrollees who will have reduced or identical premium liability year-over-year do not receive the notice, regardless of how high their new premium would be. We recommend requiring that CMS send the Chooser’s Notice to all LIS enrollees who have premium liability. This small change would help the LIS program work more efficiently and give LIS enrollees the tools they need to choose the lowest cost plans—thereby decreasing the financial burden for all stakeholders involved.

⁶ Letter from the U.S. Senate Committee on Finance to CMS Administrator Tavenner (February 5, 2014) available at: <https://califesciences.org/wp-content/uploads/2015/06/Senate-Finance-Committee-Bipartisan-Letter-Opposing-Elimination-of-Six-Protected-Classes-of-Prescription-Drugs-from-Medicare-Part-D-February-5-2014.pdf>.

Index LIS Copayments and Deductibles for LIS Enrollees to the Social Security Cost of Living Adjustment (COLA). Under current law, LIS enrollees with incomes below 100% of the federal poverty level (FPL) have their prescription drug cost sharing increased according to the Consumer Price Index, while increases for those with incomes between 100 and 150% FPL are linked to the percentage increase in average per capita aggregate expenditures for covered Part D drugs. These methodologies are long overdue for an update. The Social Security COLA is a more accurate reflection of annual income increases for these fixed-income populations and is therefore a more appropriate index to use. The current calculation for the 100-150% FPL group is particularly problematic since it increases out-of-pocket costs at a higher rate than increases in ability to pay, which erodes the value of the LIS benefit over time.

Replace LIS Random Assignment with Intelligent Assignment. Assigning LIS enrollees to new plans based on their individual prescription drug needs—so-called “intelligent assignment”—has been shown to reduce out-of-pocket and Medicare program spending. For example, a 2007 House bill, H.R. 3162, included a provision on intelligent assignment that CBO scored at \$1.2 billion in savings over 10 years.⁷ And according to a 2014 *Health Affairs* article “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.”⁸

Improve Language Access for Part D Beneficiaries. We recommend requiring that CMS translate important Part D notices, including notices of disenrollment and coverage denials, into all languages spoken by either 1,000 individuals or 5% of the population in the service area, whichever is lower. Similarly, we recommend directing the Social Security Commissioner to allow individuals to directly submit LIS applications in the 18 languages already translated.⁹ Finally we recommend requiring CMS to translate the Medicare & You Handbook into additional languages beyond Spanish and English. All of these translations are necessary to address health disparities, empower beneficiaries with limited English proficiency to access this financial assistance, and adhere to current civil rights laws.

Thank you for your consideration. We look forward to continued collaboration on efforts to improve prescription drug access and affordability for people with Medicare. Please contact me at lcopeland@medicarerights.org if you have any questions, or if we may otherwise be a resource.

Sincerely,



Lindsey Copeland
Federal Policy Director
Medicare Rights Center

⁷ 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, available at: <https://www.congress.gov/bill/110th-congress/housebill/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>.

⁸ Zhang, Zhou, and Faik, *Health Affairs*, “A Simple Change to the Medicare Part D Low-Income Subsidy Program Could Save \$5 Billion” (June 2014) available at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.1083>.

⁹ Social Security Administration, “Application for Extra Help with Medicare Prescription Drug Plan Costs” available at: <https://www.ssa.gov/benefits/medicare/prescriptionhelp/other-languages.html>.