National Council on Aging

Issue Brief

Making Prescription Drugs More Affordable for Medicare Beneficiaries

The National Council on Aging (NCOA) urges Congress to take action to make prescription drugs more affordable for Medicare beneficiaries who struggle the most with these costs, and protect access to needed prescription drugs. Our priority recommendations for improving Medicare Part D are below.

Part D Out-of-Pocket Cap

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 of $5,100. A hard cap would reduce out-of-pocket costs and enhance predictability for the approximately one 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.

Congress should consider a few factors when creating an OOP cap. For example:

- If the cap is set too high, fewer beneficiaries will hit the threshold and experience the relief from limiting their out-of-pocket expenses. We are very concerned about the impending "cliff," when the catastrophic threshold will increase at the end of this year $1,250, from $5,100 to $6,350. We recommend that the cliff be fixed, 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 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.
- 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.

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. To qualify, annual income must be below $18,972 for an individual and $25,608 for a couple, with less than $14,390 in assets for an individual and $28,720 for a couple.

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. 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. Other approaches that merit consideration include allowing beneficiaries to qualify for LIS through the absence of investment income and not counting funds in retirement savings plans such as 401(k) accounts as assets.

We also recommend that other more modest LIS improvements be made:

- Eliminate cost sharing for generic drugs;
- 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);
- Examine feasible alternatives to current LIS assignment;
- Empower and improve education for LIS enrollees by sending the Chooser's Notice to all with premium liability;
- Make all LIS applications and subsequent correspondence from SSA available in at least three additional commonly spoken languages; and
- Make LI NET permanent.

Appeals and Exceptions

The 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. We strongly support allowing the pharmacy counter refusal/denial 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.

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. 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.

Given that beneficiaries already struggle to understand the concept of coinsurance (frequently listed as a range of percentages) as displayed on Medicare Plan Finder (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. 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.

For additional details on these recommendations, go to: NCOA Comments on Congressional Part D Reform.

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