national council on aging

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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. In 2021, beneficiaries must pay 5% of their drug costs indefinitely when they exceed the current OOP threshold of $6,550. A hard cap would reduce OOP costs and enhance predictability for the over one million beneficiaries who reach the catastrophic phase each year and do not have low-income subsidies. In 2018, these beneficiaries incurred over $3,100 in OOP costs on average above the catastrophic threshold.

When establishing a statutory OOP cap, we urge Congress to consider these factors to ensure the greatest impact:

- If the cap is set too high, fewer beneficiaries will hit the threshold and experience the relief from limiting their OOP expenses. As reference, the OOP threshold for catastrophic coverage has increased from $4,550 in 2014 to $6,550 today, a nearly $2,000 increase.
- Spread OOP 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, 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 $19,380 for an individual and $26,100 for a couple, with less than $14,610 in assets for an individual and $29,160 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. Last Congress, we strongly supported Senator Casey's S. 691, Medicare Extra Rx HELP Act of 2019, which would have eliminated 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, who have incomes below 150% of the Federal Poverty Level (FPL), to the Social Security Cost of Living Adjustment (COLA);

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- Examine feasible alternatives to current LIS auto-assignment into drug plans;
- Empower and improve education for LIS enrollees by sending the Chooser's Notice to all enrollees with premium liability; and
- Make all LIS applications and subsequent correspondence from Social Security Administration available in at least three additional commonly spoken languages.

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 particularly expensive 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 OOP 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 their drug cost as $30/fill during Open Enrollment should be able to still pay the same or lower coinsurance amount in April and September. Beneficiaries are expected to enroll and be locked into a plan for one year. That said, within reason, 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. 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 the Centers for Medicare and Medicaid Services 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 Medicare Part D Reform.

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