

UNITED STATES SENATE
SPECIAL COMMITTEE ON AGING
“10 YEARS LATER: A LOOK AT THE MEDICARE PRESCRIPTION DRUG PROGRAM”
May 22, 2013

WRITTEN TESTIMONY SUBMITTED by the
MEDICARE RIGHTS CENTER

Introduction

Mr. Chairman and Members of the Committee:

As President of the Medicare Rights Center, I thank the Senate Special Committee on Aging for the opportunity to submit a written statement reflecting on ten years of prescription drug coverage made available through Medicare Part D. The Medicare Rights Center (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.

Today more than 70% of Medicare beneficiaries—over 37.2 million—are enrolled in a Part D prescription drug plan.¹ Prior to the creation of Part D, millions of older adults and people with disabilities went without adequate prescription drug coverage. Through Part D, beneficiaries gained an invaluable benefit, enhancing the affordability of and access to needed medicines. Despite this success, many beneficiaries face continued challenges accessing prescription drugs.

We know these struggles firsthand. Medicare Rights answers 15,000 Medicare questions on our national helpline each year, serving older adults, people with disabilities, family caregivers, social workers, attorneys and other service providers. Through our educational initiatives, including peer-to-peer learning networks, we touch the lives of an additional 65,000 people with Medicare and their families. Our online learning tool, Medicare Interactive, receives approximately 650,000 visits annually.²

Over the course of one year, one quarter of the calls received on the Medicare Rights helpline pertained to Medicare Part D. Most of these calls were related to enrollment and disenrollment in a prescription plan (37%) or questions regarding coverage and denials of prescribed medications

¹ MedPAC, “Report to the Congress: Medicare Payment Policy,” (March 2013), available at: http://www.medpac.gov/documents/Mar13_entirereport.pdf; Centers for Medicare and Medicaid Services (CMS), “Medicare Advantage/Part D Contract and Enrollment Data” (May 2013), available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDENrolData/Monthly-Contract-and-Enrollment-Summary-Report-Items/Contract-Summary-2013-05.html?DLPage=1&DLSort=1&DLSortDir=descending>

² Medicare Rights Center, “Medicare Interactive” (2013), available at: <http://www.medicareinteractive.org/>

(34%). The remainder of our calls concerned low-income assistance, questions like how to enroll in the Low-Income Subsidy of Medicare Part D (Extra Help), and billing issues (6%).³

Drawing from a decade of experience counseling and educating people with Medicare, our testimony will outline challenges and suggest improvements to Medicare's prescription drug benefit. We ask the members of the Committee to consider these topics for further examination as you continue to explore the merits and shortcomings of Part D.

Living with Medicare Part D: Persistent Beneficiary Challenges

Ensuring Drug Affordability:

The most common call to our helpline comes from a Medicare beneficiary having difficulty affording a health care service or a prescription medicine. The Part D benefit effectively reduced copayments and costs for generic medications and some other routine drugs. Nevertheless, many beneficiaries continue to face astronomical costs at the pharmacy counter, particularly those with a serious or rare illness.

Steps taken through the Affordable Care Act to gradually close the prescription drug coverage gap (also known as the doughnut hole) will help to improve this circumstance. Doing away with the coverage gap will improve Medicare beneficiaries' financial well-being—helping many avoid impossible choices, such as choosing between buying groceries or filling a prescription. Eliminating the doughnut hole is also likely to improve compliance and health outcomes among beneficiaries, ultimately leading to lower spending on expensive acute care. Yet, the coverage gap is only one reason medications remain unaffordable for many people with Medicare.

High copayments during the initial coverage period place a strain on low- and middle-income older adults and people with disabilities. Many people with Medicare struggle to afford high health care costs. Half of all people with Medicare—25 million beneficiaries—live on annual incomes of \$22,500 or less, and the average Medicare households spends 15% of their total income on health care costs, three times that of non-Medicare households.⁴

Access to Extra Help, Medicare's prescription drug assistance program, can reduce costs and increase access to needed medications, as shown by Claire's story. Claire recently became eligible for Medicare through disability and called the Medicare Rights helpline with a question concerning her expensive Multiple Sclerosis (MS) drugs.⁵ She is 45 years old and living in New

³ Percentages based on analysis of helpline data from May 2012 to May 2013

⁴ Kaiser Family Foundation, "J. Cubanski, "An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use" (Kaiser Family Foundation: February, 2013), available at: <http://kaiserfamilyfoundation.files.wordpress.com/2013/02/an-overview-of-the-medicare-program-and-medicarebeneficiaries-costs-and-service-use-testimony.pdf>

⁵ Please note that names were altered throughout this testimony to protect the privacy of callers.

York City. Prior to becoming Medicare eligible, Claire was enrolled in an expensive private plan which covered much of her drug costs. She called for help because her prescription costs were significantly increased under Medicare.

Claire's monthly income amounts to \$1,750 per month and she spends about \$460 of this for her Medicare coverage, including a Medigap premium (\$306 per month), a stand-alone Part D plan premium (\$47 per month), and the standard Medicare Part B premium (\$105 per month). In addition to these monthly costs, many of her prescription drugs fall into a specialty tier with a 30% coinsurance—one drug alone costs \$624 per month. Given these high costs, Claire was going to fall into the coverage gap within the first several months of the year. Because specialty tiered drugs, including Claire's MS medication, are excluded from the exceptions process, Claire had no recourse to lighten the burden of this significant expense.

To right this problem, a Medicare Rights counselor advised Claire to consider purchasing a more expensive Medigap plan. New York State allows a health care premium income disregard to lower Claire's countable income and allow her to qualify for the Medicare Savings Program. A more expensive Medigap plan will allow Claire to become eligible for the Qualified Individual (QI) program and, in turn, the Extra Help program. Beneficiaries eligible for a Medicare Savings Program are automatically eligible for Extra Help. Enrolling in Extra Help will help make Claire's drug costs affordable.⁶

Claire's story illustrates the challenges facing beneficiaries with significant health needs and high drug costs. Her case also makes clear the value of the Extra Help program. Still, many who are eligible for Extra Help are not enrolled—approximately 2.3 million beneficiaries fall into this category.⁷ Further, Extra Help is only available to very low-income beneficiaries.

Full assistance for Part D premiums and copayments is provided only to those with annual incomes at or below 100% of the federal poverty level (FPL), about \$11,500, and access to partial assistance drops off at annual incomes levels above 150% FPL, or \$17,200. In addition, Extra Help eligibility is subject to strict asset tests, up to \$13,300 for an individual or about \$26,600 for a couple.⁸

⁶ It is important to note that New York State is unique in many respects with regards to Extra Help. Unlike other states, New York allows for a health insurance premium disregard to count towards eligibility in the Medicare Savings Programs and also allows for continuous open enrollment in Medigap plans. Further, many states do not have a Medigap option for Medicare beneficiaries who are under the age of 65. In short, Claire's residency in New York State is what allowed her an option to afford the medication she needs.

⁷ Letter to Congress on need for Medicare Improvements for Patients and Providers Act (MIPPA) two-year funding extension, (December 2012), available at: <http://www.nasuad.org/documentation/newsroom/Extenders-Low-Income-Outreach-Funding-Letter-12-12.pdf>

⁸ Medicare Rights Center, "Extra Help Program: Income and Asset Limits 2013" (2013), available at: <http://www.medicarerights.org/fliers/Help-With-Drug-Costs/Extra-Help-Chart.pdf?nrd=1>

Efforts should be made to enhance the Extra Help benefit. First, enrollment in Extra Help should be bolstered through data sharing designed to streamline eligibility and application processes. States should be encouraged to facilitate this process, as allowed by the Medicare for Patients and Providers Improvement Act of 2008, and these activities should be adequately funded.

Second, the asset test for Extra Help should be eliminated. Past research indicates that the asset test is the most significant barrier to enrollment.⁹ Asset limits complicate the application process, triggering onerous documentation requirements and forcing beneficiaries to determine the cash value of various insurance and retirement policies. Further, unreasonably low asset tests prohibit beneficiaries who worked hard over their working lives to secure only modest savings from accessing needed assistance.¹⁰

Diminishing Plan Complexity:

While it is important for beneficiaries to have choices with regard to prescription drug plans, having *too* many choices and *too* many variables to select from becomes overwhelming for many people with Medicare. This needless complexity causes many beneficiaries to forgo the selection process entirely or leads to unwise plan selections. According to the National Bureau of Economic Research, Part D beneficiaries spent an average of \$300 in unneeded costs per year.¹¹

These unwise choices result from an inability to identify the most cost-effective plan. Beneficiaries often rely on informal recommendations from friends or family members, or they simply choose the plan advertised most frequently in a given area. And for beneficiaries who lack access to Plan Finder or are unable to navigate the tool, selecting a Part D plan amounts to little more than a complicated guessing game.

To get the most out of one's drug coverage, a beneficiary must know the differences between preferred brand name drugs vs. non-preferred brand name drugs vs. preferred generic drugs vs. non-preferred generic drugs vs. specialty drugs. In addition, a beneficiary must know how to obtain drugs from preferred in-network pharmacies vs. non-preferred in-network pharmacies vs. mail order pharmacies, and whether or not one's prescriptions are subject to any restrictions.

In particular, plans are currently structured with many tiers—which include different cost sharing obligations for various types of covered drugs. Limitations on coverage, like prior authorization

⁹ Access to Benefits Coalition and National Council on Aging, “Strategies to Improve the Medicare Part D Low-Income Subsidy” (January 2007)

¹⁰ Medicare Rights Center “Expanding Eligibility for Medicare Savings Programs: The Case for New York State” Medicare Rights Center, December 2007”; Medicare Rights Center, “Maximizing MSP Enrollment with Part D: Lessons from Three States,” (May 2006)

¹¹ F. Heiss, A. Leive, D. McFadden, and J. Winter, “Plan Selection in Medicare Part D: Evidence from Administrative Data,” (NBER: January 2012), available at: http://www.nber.org/papers/w18166.pdf?new_window=1

requirements, step therapy and quantity limits, combined with high cost sharing in some tiers, creates needless strain for people with Medicare. Often, beneficiaries are told a plan “covers” a particular medication only to be surprised by additional restrictions or added costs for needed drugs once enrolled in the plan.

We are encouraged by recent efforts undertaken by the Centers for Medicare and Medicaid Services (CMS) to reduce duplicative plan offerings and to ensure that there are meaningful differences between plans. Still, we believe more can be done. The Medigap program offers a useful model for Medicare Part D. When selecting a Part D plan, beneficiaries should be able to make apples-to-apples comparisons among standardized plans, as opposed to the apples-to-oranges comparisons required of people with Medicare under the current scheme.

Making Plan Finder a Robust Tool:

The complexity of Part D plan offerings underscores the importance of having access to an intuitive, accurate and functional search tool. For this purpose, Medicare beneficiaries and the professionals who help them currently rely on Plan Finder, a comprehensive online tool made available by CMS. While Plan Finder has improved significantly since the beginning of Part D, the number of plans, types of choices and medical jargon beneficiaries must navigate when using Plan Finder is often overwhelming.

People with Medicare must enter complex information in order to maximize use of Plan Finder, including: making a selection about how to receive one’s drugs, by mail order or by choosing from a list of local pharmacies; entering all prescriptions, including dosage and frequency; and parsing the relative costs of higher premiums compared to lower copayments alongside noted coverage restrictions. All of this makes for a daunting experience.

We believe that Plan Finder could be significantly improved by facilitating greater personalization, such as by storing beneficiary data from prior years, displaying cost information based on specific coverage phases (initial phase, coverage gap and catastrophic phase) and providing only one group of charts with cost information specific to each drug, indicating differences between mail-order and retail sources.¹²

Improving Medicare Part D Appeals:

Each year, Medicare Rights receives up to 5,000 calls from people with Medicare, family caregivers and service providers seeking help with Medicare appeals and coverage-related issues. Many of these calls are from beneficiaries or caregivers recently refused a prescription at the pharmacy counter. Often, people refused access to a drug are not told the reason their

¹² For more detailed recommendations, contact Medicare Rights Center for a memo to CMS dated March 13, 2013.

prescriptions are not being filled. Pharmacists tend to have no or, at best, incomplete information and can only direct the person to call their drug plan for the denial reason.

As such, the onus is on the beneficiary to investigate the reason a prescribed drug is being refused at the point-of-sale. Once a drug is denied at the counter, beneficiaries must embark on a tedious, fact-finding search to learn the reason a drug was refused and then to figure out whether or not an appeal is the best path forward. This is an experience shared by most callers to the Medicare Rights helpline who seek help with a coverage denial.¹³

We believe the current appeals process should be streamlined and clarified to promote the health and well-being of people reliant on Medicare Part D. In particular, Medicare beneficiaries should be made aware of the reason behind a denial at the pharmacy counter through a standardized notice with tailored information. Further, people with Part D should be able to initiate the appeals process at the pharmacy counter.¹⁴

Navigating Complex Coverage Rules:

As noted above above, Congress and CMS should make significant improvements to the Part D appeals process to allow for timely, affordable and effective use of prescribed medications. Yet, barriers remain for which the appeals process is inapplicable, including: limitations on coverage for off-label uses and the unique treatment of specialty tier drugs.

Each year, Medicare Rights receives calls from people facing denial of needed medication by their Part D plan because the drug is prescribed for a condition other than the condition for which the drug was approved by the Food and Drug Administration (FDA)—known as “off-label” uses. Often these off-label uses are supported in peer-reviewed scientific journals and prescribed for rare diseases or unusual presentations, yet these uses remain excluded from Part D coverage.

For example, Tanya’s husband called Medicare Rights inquiring about her prescription for Provigil to treat her anhedonia, a condition commonly associated with severe depression. The usual treatment for this condition, an amphetamine, was not appropriate for Tanya because of her history of seizure and stroke. Tanya’s treating physician and the head of neurology at a nearby hospital provided evidence that Provigil is accepted for this use in the medical community. In addition, Tanya’s doctor confirmed that all other medications she tried to improve her cognitive function had failed. Still, coverage was denied by Tanya’s Part D plan at all levels of appeal.

Similarly, beneficiaries who take medications placed on a Part D plan’s “specialty tier” are without recourse through an appeals process. People with Medicare who are unable to take a

¹³ Medicare Rights Center, “Facts & Faces: Refused at the Pharmacy Counter – How to Improve Medicare Part D Appeals,” (Winter 2013), available at: <http://www.medicarerights.org/pdf/2013-Facts-and-Faces-Pharmacy-Counter.pdf>

¹⁴ Medicare Rights Center, “Facts & Faces: Refused at the Pharmacy Counter – How to Improve Medicare Part D Appeals,” (Winter 2013), available at: <http://www.medicarerights.org/pdf/2013-Facts-and-Faces-Pharmacy-Counter.pdf>

“preferred tier” brand name drug are able to seek a tiering exception, an appeal to have the “non-preferred tier” brand name drug that is appropriate for the individual covered at the cost-sharing rate of the “preferred tier” drug. Yet, brand name drugs in the category of “specialty tier” are not eligible for an appeal to a lower tier. Beneficiaries who need drugs on a specialty tier often pay unreasonably high copayments for these medicines or simply go without because the costs are unaffordable.

At a minimum, Congress should enact legislation to allow tiering exceptions for specialty tier drugs, like that envisioned by the Part D Beneficiary Appeals Fairness Act (H.R. 3616 in the 112th Congress). Beneficiary challenges related to off-label uses and tiering exceptions deserve further scrutiny and require policy change. We look forward to working with members of Congress to explore these issues further and to develop detailed recommendations with the goal of enhancing the health and economic well-being of Medicare beneficiaries.

Commonsense Medicare Savings: Securing Lower Drug Prices

As evidenced above, much can be done to improve the Part D program for the older adults and people with disabilities who need prescription drug coverage. In addition, there are many options available to improve the Medicare Part D program for American taxpayers. Congress should pursue policy options to allow the federal government to secure more reasonable prices for prescription medicines provided through Medicare Part D.

In particular, we urge members of Congress to support the restoration of drug rebates for low-income Medicare beneficiaries. Prior to passage of the Medicare Modernization Act, the federal government benefited from mandated discounts provided by drug manufacturers for medicines provided to beneficiaries dually eligible for Medicare and Medicaid. Today this discount still applies for Medicaid beneficiaries, but was rescinded for dually eligible beneficiaries whose coverage switched to the Part D benefit in 2006.¹⁵

We believe that Congress should restore these rebates. According to the Congressional Budget Office, restoration of Medicare rebates would save \$133.7 to \$141.2 billion over ten years. This prudent cost saver would help strengthen Medicare’s financial footing—all while doing no harm and shifting no costs to people with Medicare.¹⁶

¹⁵ Leadership Council of Aging Organizations, “Build on What Works: Restoring Medicare Drug Rebates” (January 2013), available at: <http://www.lcao.org/files/2013/02/LCAO-Drug-Rebates-Issue-Brief-Jan2013.pdf>

¹⁶ Congressional Budget Office (CBO), “Estimated Effects on Direct Spending and Revenues for Health Care Programs of Proposals in the President’s FY2014 Budget,” (May 2013), available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/44247_APB_HealthCarePrograms.pdf; Committee on Energy and Commerce, “Democratic Leaders Introduce Legislation to Save Taxpayers More Than \$140 Billion in Medicare Drug Costs,” (April 2013), available at: <http://democrats.energycommerce.house.gov/index.php?q=news/democratic-leaders-introduce-legislation-to-save-taxpayers-more-than-140-billion-in-medicare-dr>; Office of Senator J. Rockefeller, “Press Release: Rockefeller and 18 Other Senators Introduce Legislation to Protect Seniors & Reduce Deficit by \$141.2 Billion”, available at: <http://www.rockefeller.senate.gov/public/index.cfm/press-releases?ID=617ffeb-4c5a-4123-a5b3-1f8b790e5f8b>

In addition, we urge Congress to explore additional policy options to strengthen the Medicare program's ability to secure the best possible prices on prescription drugs. These include creating a publicly administered prescription drug benefit, such as that envisioned by the Medicare Prescription Drug Savings and Choice Act (S. 408 and H.R. 928).

Also, Congress should lift the prohibition on the U.S. Secretary of Health and Human Services barring direct negotiations with pharmaceutical manufacturers, as reflected in the Medicare Prescription Drug Price Negotiation Act of 2013 (S. 117 and H.R. 1102) and the Prescription Drug and Health Improvement Act of 2013 (S. 77).

Conclusion:

Part D is a success in that it provided drug coverage for millions of Americans who had limited or no coverage prior to its enactment. Yet, as demonstrated above, the Part D program is not without its flaws. These persistent challenges must be addressed in order to ensure affordable access to needed prescription drugs for people with Medicare.

Thank you for the opportunity to submit a written statement.

A handwritten signature in black ink, appearing to read "Joe Baker". The signature is fluid and cursive, with the first name "Joe" being more prominent than the last name "Baker".

Joe Baker
President
Medicare Rights Center

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