Protect and Strengthen Medicare

Improving the Effectiveness of Extra Help for Prescription Drugs

The Problem

Medicare's Low-Income Subsidy (LIS) program (also called "Extra Help") can be a lifeline, helping low- and moderate-income beneficiaries pay for coverage they would not otherwise be able to afford. But aspects of the program are woefully outdated, making it difficult for low- and moderate-income beneficiaries to access the help they need.

Background

LIS is a federal program that helps people with limited incomes and savings pay for their Medicare prescription drug coverage, including coinsurance, deductibles, and premiums. Currently, the program has two subsidy levels—full and partial—which are tied to a beneficiary's income and resources as outlined in the chart below (sourced from Medicare Interactive). In 2024, the partial subsidy level will be eliminated and the full subsidy extended to cover people with an income at or below 150% of the poverty level.

Income limit	Asset limit	Program	Copayments
Below $1,843 ($2,485 for couples) per month **And** your income and/or assets are above Full Extra Help limits	**Up to** $16,660 ($33,240 for couples) **And** your income and/ or assets are above Full Extra Help limits	**Partial Extra Help** Premium depends on your income $104 deductible or the plan's standard deductible, whichever is cheaper	15% coinsurance or the plan copay, whichever is less After $7,400 in out-of-pocket drug costs, you pay $4.15/generic and $10.35/brand-name or 5% of the drug cost, whichever is greater
Up to $1,660 ($2,239 for couples) per month	**Up to** $10,590 ($16,630 for couples)	**Full Extra Help** $0 premium and deductible	$4.15 generic copay $10.35 brand-name copay No copay after $7,400 in out-ofpocket drug costs

These financial eligibility thresholds are extremely low, especially as prescription drug costs continue to climb and take up a larger share of beneficiaries' limited budgets. Despite the important advancements in the Inflation Reduction Act (IRA) of 2022 which will set a $2000 cap on beneficiary out-of-pocket spending in Part D in 2025 and allow Medicare to negotiate drug prices, older adults and people with disabilities who are struggling to afford their prescriptions but are unable to qualify for help may be forced to choose between paying for Medicare and other basic needs, like food and rent.

Those who do qualify may still face program barriers that put their health and economic security at risk. Older adults and people with disabilities who have Extra Help may still experience challenges accessing affordable care. They may be unable to afford the cost sharing for their medications, may not be aware that they can enroll in a lower cost plan, or may be automatically enrolled into a plan that does not suit their needs in some way, including not covering all of their needed medications. Each of these issues can lead to beneficiaries going without the prescriptions they need to stay safe and healthy.

Case Studies

Ms. C takes many medications, including insulin. She cannot afford the cost sharing, even though she has Extra Help. Her insurer has a program to subsidize her insulin costs, but she's only eligible if she dis-enrolls from LIS, which would cause her to face higher copays for her other prescriptions.

Ms. S was auto-enrolled in a Part D plan that she did not want. When she tried to switch to another, lower-cost option, she became overwhelmed and gave up.

Mr. M just enrolled in a new Part D plan and Extra Help. He is struggling to afford the copays, $3.60 for generic medications and $8.95 for brand-name drugs.

Possible Solutions

For LIS beneficiaries, even minimal costs and administrative complexities can be barriers to access. The following reforms are needed make the program more effective:

- **Eliminate Cost Sharing on Generics.** Eliminating cost sharing on all generics would reduce financial burdens for low-income beneficiaries and increase their 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.

- **Update the LIS "Choosers Notice."** CMS publicizes conflicting information about the "Choosers Notice." One source says it goes to LIS enrollees if their "plan's premium is changing." Another source says it goes to those with LIS who "who will be liable for a portion of their plan's premium next year." The notice itself references a change in premium. We urge CMS to ensure that all choosers with premium liability receive the notice about their options to choose a $0 premium plan to ensure they can make informed, low-cost coverage choices. To avoid confusion, we also encourage an edit to the notice itself to show that the chooser has a plan premium whether or not it is changing.

- **Allow Intelligent Assignment.** The current practice is to assign LIS enrollees into new plans randomly. This can result in poor fit between beneficiary needs and plan design. Using intelligent assignment based on their individual prescription drug needs would better match enrollees with available plans—improving beneficiary access to needed drugs, reducing their out-of-pocket costs, and lowering Medicare program spending.