

# Streamlining Part D Appeals Process Act

(S. 1861/H.R. 3924)

## Case Study

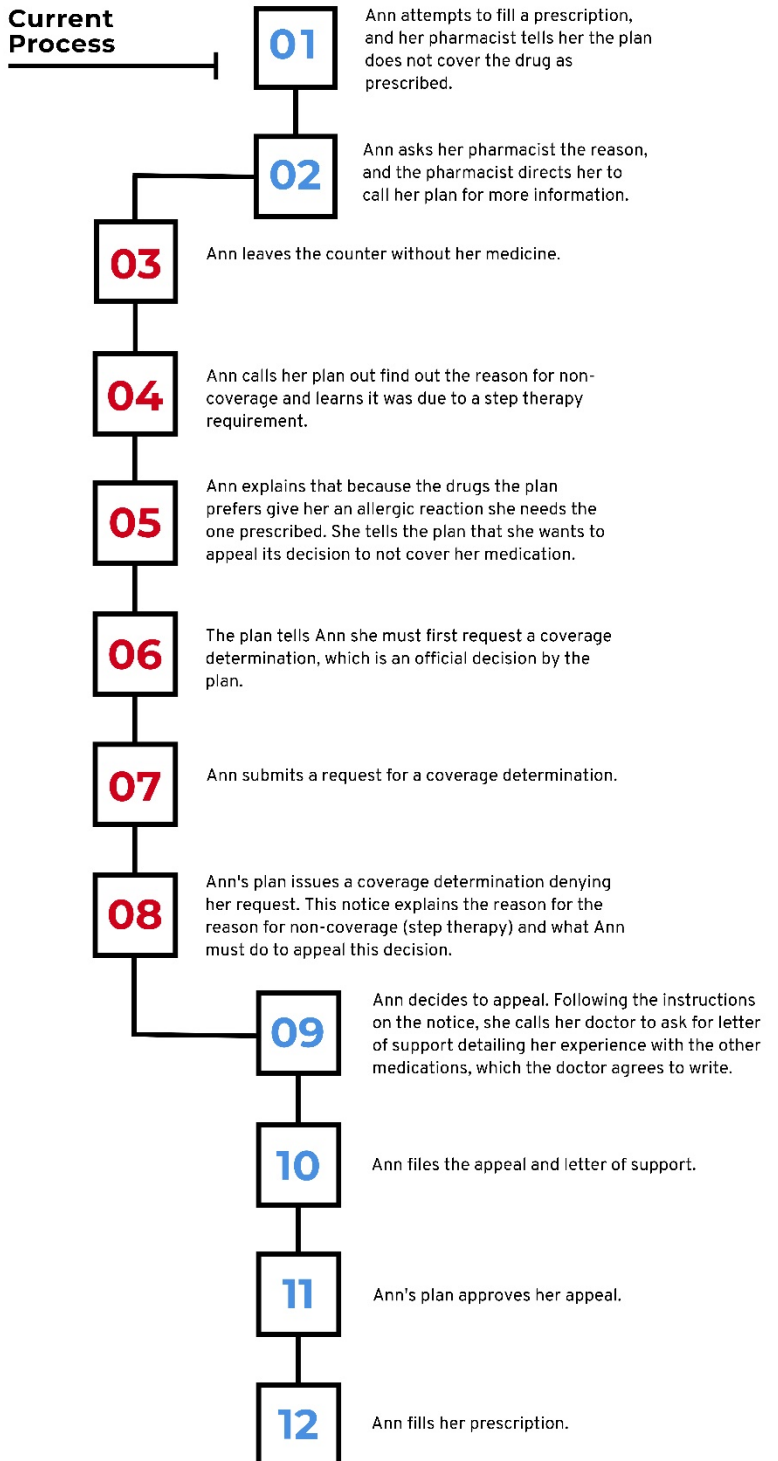
"I went to the pharmacy to fill my prescription for high blood pressure. But my pharmacist would not give me the medicine, and he could not tell me why my prescription was denied. He told me to call my drug plan to find out. So I left the pharmacy without my prescription and went home to call my plan. The plan told me that I needed to try a different kind of medicine before I could have the one my doctor prescribed.

I told my plan that a year ago, I took the other blood pressure drug and had a severe allergic reaction, which is why my doctor prescribed something different this time. My plan told me that I had to request a coverage determination, which I did. I got that letter a few days later. It explained that my prescription was denied because there were alternative medicines available, and outlined what I needed to do to appeal this decision. Following those instructions, I asked my doctor to write a letter of support explaining why I need the medication as prescribed.

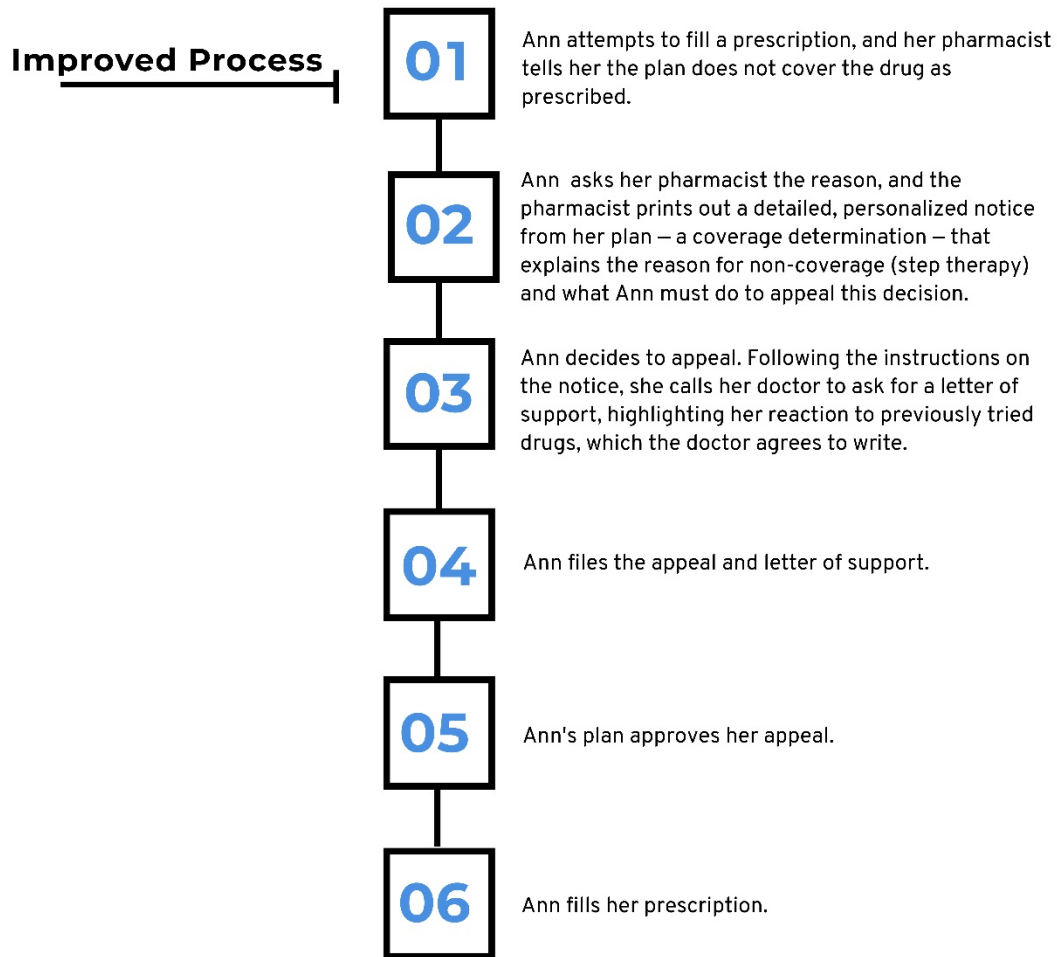
I filed the appeal and sent in the letter and was relieved when my plan finally let me have my medicine. It was hard to go without it while I waited on my plan's decision. During this time, my blood pressure went up and I felt exhausted and light-headed. Without my medicine, I was really worried. I am glad the appeal worked out and that I have the medicine my doctor prescribed, but who knows what I will go through next year."

—Ann from Tampa, FL

### Current Process



Had S. 1861/H.R. 3924 been in place at the time when Ann’s prescription was refused at the point-of-sale, her experience would have been quite different, as illustrated below:



Reforms to the Part D appeals process are long overdue, a need made ever-more urgent by a growing Medicare-eligible population, the increased use of utilization management strategies by plans, and ongoing efforts to tackle high and rising prescription drug prices—all of which could push more beneficiaries into this broken system.

Forcing additional consumers to work through this process would only exacerbate and amplify its failures, to the detriment of people with Medicare. We urge policymakers to address systemic inefficiencies within the Part D appeals process—namely the lack of information provided to beneficiaries at the time of a pharmacy counter denial and the subsequent requirement that a beneficiary obtain a separate coverage determination—without delay, by enacting S. 1861/H.R. 3924.