



# **Congress Must Streamline the Medicare Part D Prescription Drug Appeals Process**

S.1861/H.R.3924 Would Reduce Barriers to Access and Affordability for People with Medicare

The Medicare Part D appeals process is an essential safety valve that allows older adults and people with disabilities to access and afford needed prescriptions. However, complexities in the current system can make it difficult for beneficiaries to obtain the relief they need.

On Medicare Rights' National Consumer Helpline, we frequently hear from Part D enrollees who are struggling with appeals and coverage-related issues. Many of these callers were told at the pharmacy counter that their plan would not cover their medication—but not the reason why. Medicare puts the onus on these enrollees to investigate the reason for the denial and to figure out what to do with that information.

Pharmacists do not tend to have details about the coverage decision, and can only direct enrollees to contact their plan for an explanation. As a result, affected enrollees may have no choice but to leave the pharmacy without their medication or a clear understanding of why it was denied. Confused about what to do next, some may bypass the appeals process, returning later to pay what they can out-of-pocket, or decide to forego the medication altogether.

Those who do take action must embark on a tedious fact-finding mission. This includes calling their plan to learn why the medication was refused—because of a formulary or coverage restriction, for example—and working with their physician to determine the best path forward, such as trying an alternative drug or appealing for coverage of the medication as prescribed.

Beneficiaries who decide to appeal must then re-engage with their plan to obtain a written denial that explains the plan's reason for non-coverage—even though the plan has already issued a denial at the pharmacy counter, and even though the beneficiary has already contacted their plan to learn why. Only upon receipt of this "official" notice, known as a coverage determination, may a beneficiary request a formal appeal.

This process is overly onerous and deeply flawed. Beneficiaries can find it difficult to manage these multiple—and often duplicative—phases of coordination and consultation, each of which requires many phone calls, long wait times, and significant persistence. At the same time, adhering to these complicated rules can also create administrative burdens for plans, pharmacists, and providers. Together, these inefficiencies can lead to delays in beneficiary access to needed prescriptions, abandonment of medications, reduced adherence to treatment protocols, worse health outcomes, and higher costs.

The bipartisan, bicameral Streamlining Part D Appeals Process Act (S. 1861/H.R. 3924), introduced by Senators John Cornyn (R-TX) and Ben Cardin (D-MD) and Representatives Tom Suozzi (D-NY) and

Tom Reed (R-NY), would meaningfully address these challenges. By allowing a refusal at the pharmacy counter to function as the plan's initial coverage determination, this bill would:

- Trigger the provision of a detailed, formal denial notice at the point-of-sale, giving people with Medicare more timely access to actionable information about their plan's coverage decision; and
- Eliminate unnecessary steps within the current system—including the need for beneficiaries to request pre-coverage determination information and counsel from their plans and providers—thereby empowering beneficiaries to more expeditiously exercise their appeal rights and obtain an independent review.

These much-needed improvements would help ensure that current and future Medicare beneficiaries can better access, understand, and manage the Part D appeals process.