National Alliance on Mental Illness

June 6, 2019

The Honorable Richard E. Neal
The Honorable Kevin Brady
Committee on Ways & Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Frank Pallone, Jr
The Honorable Greg Walden
Committee on Energy & Commerce
U.S. House of Representatives
Washington, DC 20515

via email PartDImprovements@mail.house.gov

Dear Chairman Neal, Chairman Pallone, Ranking Member Neal and Ranking Member Walden:

On behalf of the National Alliance on Mental Illness (NAMI) I am pleased to submit the following comments in response to your Committees' joint proposals to enact additional reforms to refine and improve the Medicare Part D program. As the nation's largest organization representing people living with mental illness and their families, NAMI believes that the Part D program has been successful in offering quality coverage for prescription drugs while remaining popular among Medicare beneficiaries.[1]

Despite this success, there is still room for improvement in Part D around access to medications, beneficiary purchasing information, and out-of-pocket (OOP) costs. In particular, the absence of an OOP cap is one of the largest challenges inhibiting the program from adequately meeting the health care needs of Medicare beneficiaries. Congress needs to address these issues.

Improvements to the Low-Income Subsidy (LIS) Program

Medicare beneficiaries living with mental illness are disproportionately represented in the populations eligible for the LIS or "Extra Help" program. This includes both beneficiaries that receive LIS and those who are dually eligible for both Medicare and Medicaid. These beneficiaries are all below 135 percent of the federal poverty level (FPL). As such, they rely on the LIS program in order to access Part D with $0 monthly premium and minimal cost sharing.

While the LIS has worked well to increase access to prescription drugs for low-income beneficiaries, improvements are needed. First, Congress should consider eliminating the asset test, which would streamline LIS program administration. Only Part D enrollees that meet an exceptionally low asset threshold (amounting to $7,730 for an individual for full benefits) are currently eligible for assistance with their Part D premiums and cost-sharing. The verification of asset information is burdensome to administer and presents a significant barrier to program enrollment.

Congress should also provide full LIS benefits to those living on the edge of poverty. Only the lowest-income individuals with Medicare receive full benefits through LIS. Individuals with incomes of about

[1] Medicare Today, "2018 Senior Satisfaction Survey," 2018, http://medicaretoday.org/resources/senior-satisfaction-survey/.

$16,860 to $18,735 (135 percent to 150 percent in 2019) that also meet the program's asset test are exposed to premiums, deductibles, and high coinsurance rates (15 percent). NAMI would urge your Committees to follow the example of S. 691, the Medicare Extra Rx Higher Eligibility Limits in Part D Act of 2019, that would extend full LIS benefits to individuals below 200 percent of FPL.

Finally, NAMI urges the Committees to improve the LIS program by:

- Removing the burdensome asset test, and
- Eliminating cost-sharing for generics for full benefit dual eligible beneficiaries.

Putting in Place an Out of Pocket (OOP) Cap in Part D

NAMI urges your Committees to put in place an OOP cap for Medicare Part D to limit the amount Medicare beneficiaries pay for covered prescription drugs. The draft legislation is a good starting point in establishing such a cap. A monthly cap or other mechanism that would allow total OOP costs to be distributed more evenly throughout the year is long overdue in Part D. This would ease the financial strain for beneficiaries that currently are confronted with paying a significant percentage of their total OOP financial burden at the beginning of each benefit year.

An OOP cap will help ensure Medicare beneficiaries have access to vital and life-saving medicines. Currently, once beneficiaries reach the catastrophic coverage threshold their out-of-pocket responsibilities are at 5%, but they do not have a cap. This means that very expensive drugs are a huge burden to beneficiaries. This is unlike the experience most beneficiaries face with commercial coverage, where there is a single OOP cap for all covered services, or in Medicare Part B, where beneficiaries have other OOP protections such as the ability to purchase supplemental coverage. Supplemental coverage and OOP caps protect consumers from unaffordable cost-sharing and enable them to better anticipate and meet their health care related financial obligations.

A majority of Medicare beneficiaries live with two or more chronic conditions[2], and many are reliant on specialty medications for their treatment. The proliferation of specialty tiers, subject to significant coinsurance and excluded from cost-sharing exceptions, forces beneficiaries to pay a significant percentage of a medication's cost. For drugs that are placed on specialty tiers by Part D plans, the coinsurance amounts can range anywhere from 25 percent to 33 percent, leaving beneficiaries paying thousands of dollars in OOP costs for drugs and biologics used to treat cancer, multiple sclerosis, rheumatoid arthritis, and other disabling, serious, and life-threatening conditions. As a result, beneficiaries often cannot access the most clinically appropriate medication because financially it is out of reach, especially with median income among Medicare beneficiaries of just over $26,000.[3]

An OOP cap would be a critical protection for beneficiaries that reach the catastrophic coverage phase of Part D and are forced to pay 5 percent coinsurance until the next calendar year, when the cycle starts anew. The catastrophic coverage phase 5 percent cost-sharing requirement can impose an overwhelming financial burden on beneficiaries and can impede access needed therapies. Currently, the average Medicare beneficiary will pay approximately $2,750 in OOP costs by the time they reach the

[2] KA Lochner and CS Cox, "Prevalence of Multiple Chronic Conditions Among Medicare Beneficiaries, United States, 2010," Prev Chronic Dis. 2013 Apr 25;10:E61. doi: 10.5888/pcd10.120137.
[3] Gretchen Jacobson et al., "Income and Assets of Medicare Beneficiaries, 2016-2035," Kaiser Family Foundation, April 2017, https://www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2016-2035/.

catastrophic threshold. As such, NAMI encourages your Committees to consider an OOP cap well below this amount.

In addition to establishing an OOP cap, NAMI recommends that the Committees address Part D OOP costs by:

- Repealing the substantial increase in the catastrophic threshold due to occur in 2020, which will cost Medicare Part D beneficiaries an additional $1,450 out of pocket before they reach the catastrophic coverage phase; and
- Permitting Part D beneficiaries to seek a lower cost share for specialty medications through the exceptions and appeals process.

Keep the Donut Hole Closed

Medicare Part D beneficiaries who have high prescription drug expenses currently must pay more once the total cost of their medicines reaches a certain threshold. This is the result of one aspect of the benefit knows as the coverage gap or "donut hole." The cost of prescription drugs during the donut hole remains a concern of NAMI. NAMI greatly appreciates that the Bipartisan Budget Act of 2018 (P.L. 115-123) included a provision to decrease Part D enrollees' out-of-pocket costs for drugs in the coverage gap from 35 percent of total costs in 2018 to 25 percent in 2019. This provision was an important way to ensure that Part D beneficiaries who have high prescription drug costs are not left without coverage during the part of the year in which they are in the donut hole.

Beneficiary Purchasing Information

NAMI encourages the Committees to improve beneficiaries' ability to understand the benefits provided in a Part D or Medicare Advantage (MA) plan, along with coverage levels and OOP costs, when determining which plan best meets their needs. In addition to improving prospective and real-time price transparency, Part D and MA plans should be required to provide clarity and transparency on coverage and consumers' OOP costs. A mix of copayments and coinsurance can cause significant confusion, especially for individuals on multiple and/or expensive medications who are trying to navigate the system and compare plans.

Congress should direct the Centers for Medicare and Medicaid Services (CMS) to improve the beneficiary online shopping experience and ability to compare formularies and OOP costs across plans. As recently recommended by the National Council on Aging, Medicare Plan Finder would benefit from a comprehensive redesign and ongoing investment to remain relevant. NAMI recommends that Medicare Plan Finder display costs with more precision, so that enrollees can view actual premium costs, coinsurance amounts in dollars, and copayments, rather than percentages.

Need for Increased Oversight

Since its enactment, Medicare Part D has successfully offered consistent access to medications for most beneficiaries. This success is built largely upon policies such as the "6 protected classes" requirement that directs Part D plans to include on their formularies "all or substantially all" of the medications in six therapeutic classes, including antipsychotics and antidepressants. However, there is still room for improvement with respect to patient access. There are still Part D plans on the market that are offering narrow formularies, eroding beneficiary protections, imposing strict utilization management practices

and using preferred pharmacy networks. In addition, the exceptions and appeals process in Part D is difficult for many beneficiaries to navigate without assistance. NAMI urges the Committees to consider – and seek to address – these issues as you work to strengthen Part D. Your Committees should continue your oversight of CMS and Part D plans to ensure that these access challenges are addressed.

Conclusion

Thank you for the opportunity to respond to these current proposals to improvement the Medicare Part D program. If you have any questions, please contact Andrew Sperling, Director of Legislative Advocacy, at asperling@nami.org.

Sincerely,

Hannah Wesolowski
Acting National Director, Advocacy & Public Policy
NAMI, National Alliance on Mental Illness