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# Medicare Part D 101

# July 22, 2021

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# Bonnie Duffy

## *MAPRx Convener*

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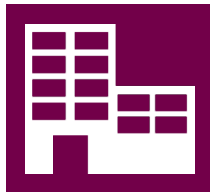
# Corey Ford

## *Xcenda*

# Medicare overview

Medicare Part D is the program's prescription drug benefit for beneficiaries



**Part A**
Inpatient care, hospice care, limited home health

**Part B**
Outpatient care (eg, physician services, laboratory services, physician-administered drugs)

**Part C**
Managed care program covering Parts A and B services

**Part D**
Prescription drug benefit for oral and self-administered drugs

# Snapshot of Medicare Part D

Medicare Part D has long been hailed a success; however, significant access and affordability challenges remain

**Popular Program**

- Beneficiary satisfaction scores are generally high
- Enrollment in Part D continues to climb every year since the program launched in 2006

**Under Budget**

- Part D has consistently cost less annually compared to initial projections by the Congressional Budget Office

**Access Challenges**

- Beneficiary out-of-pocket (OOP) costs for expensive specialty products are relatively high
- Lack of appeals options for specialty products affects access

# Part D plan options

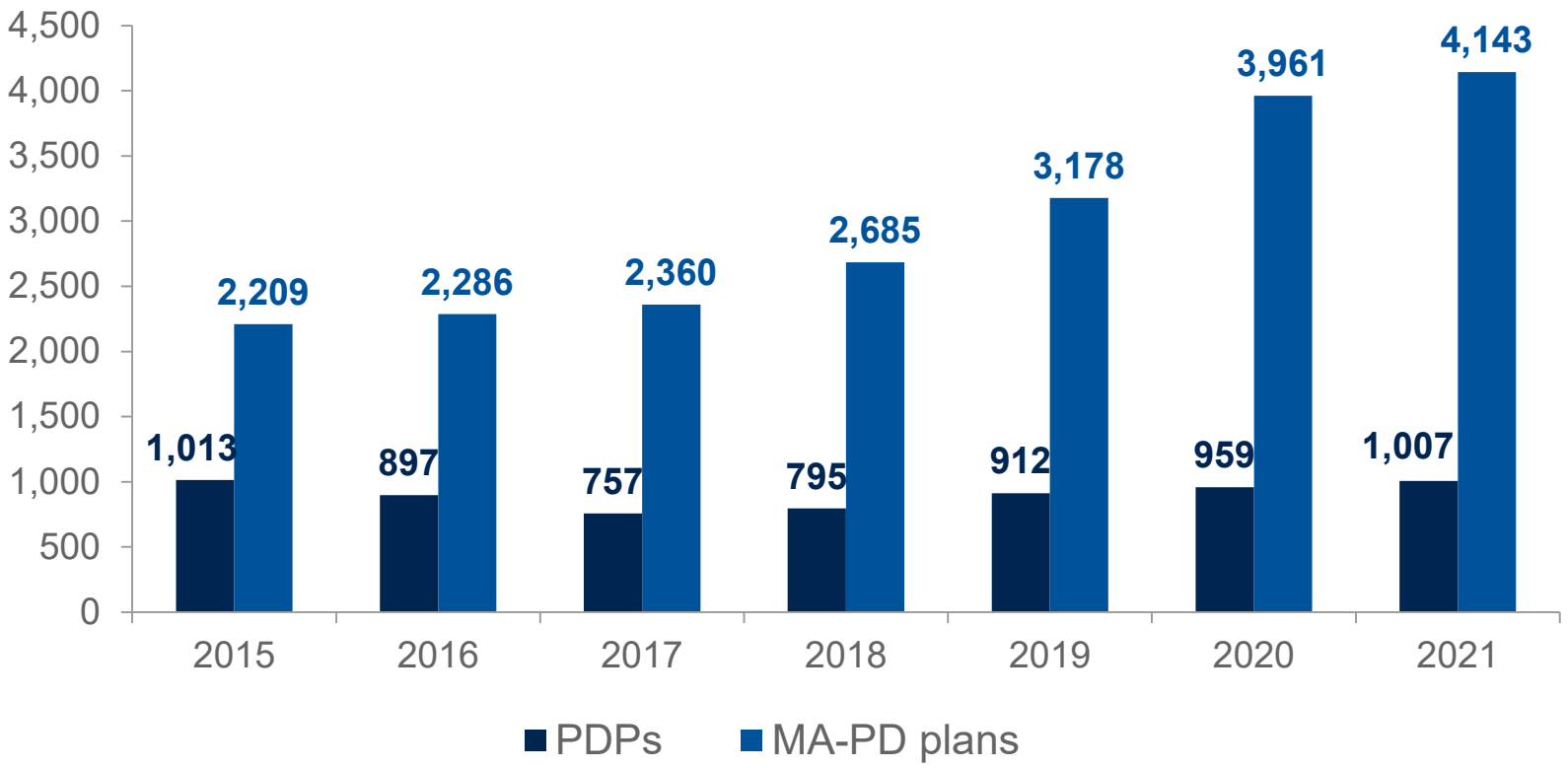
Three types of Part D plans are available for eligible beneficiaries

| Standalone Prescription Drug Plans (PDPs) | Medicare Advantage Prescription Drug (MA-PD) Plans | Employer Group Waiver Plans (EGWPs) |
|---|---|---|
| PDPs are standalone plans that supplement Medicare fee-for-service benefits (Part A and B) with prescription drug coverage | MA-PD plans cover traditional Medicare services and prescription drugs for patients enrolled in Medicare Advantage plans | EGWPs provide Part D coverage via employer or union groups for Medicare-eligible employees or retirees (both for MA-PD plans and PDPs) |

# Part D plan availability

After a declines from 2015 to 2017, the number of participating PDPs and MA-PD plans continue the upward trajectory, with continued growth in options in 2021

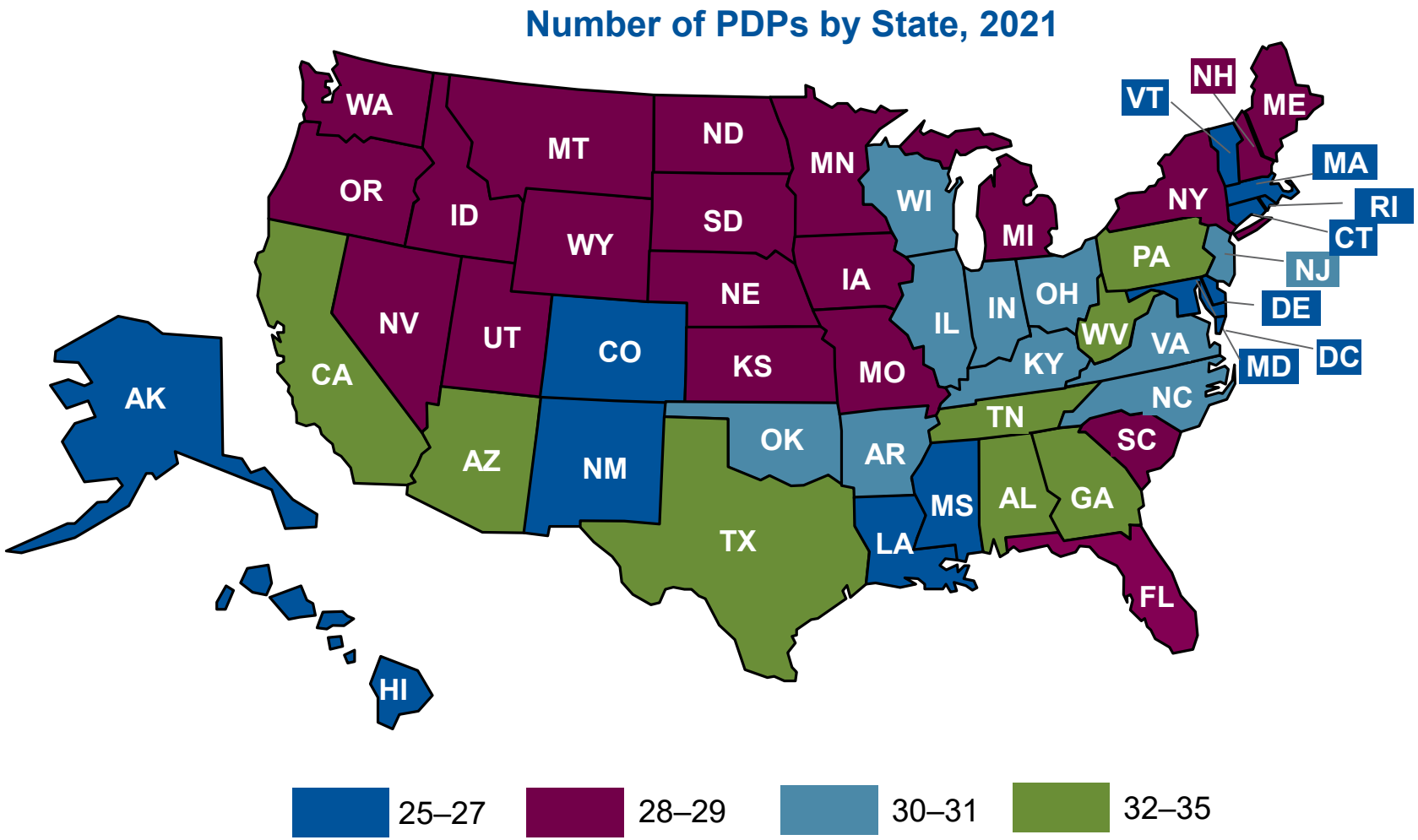
**Total Number of PDPs and MA-PD Plans, 2015–2021**




Source: Xcenda analysis of the PDP and MA landscape files from 2015 to 2021.

# Part D plan availability

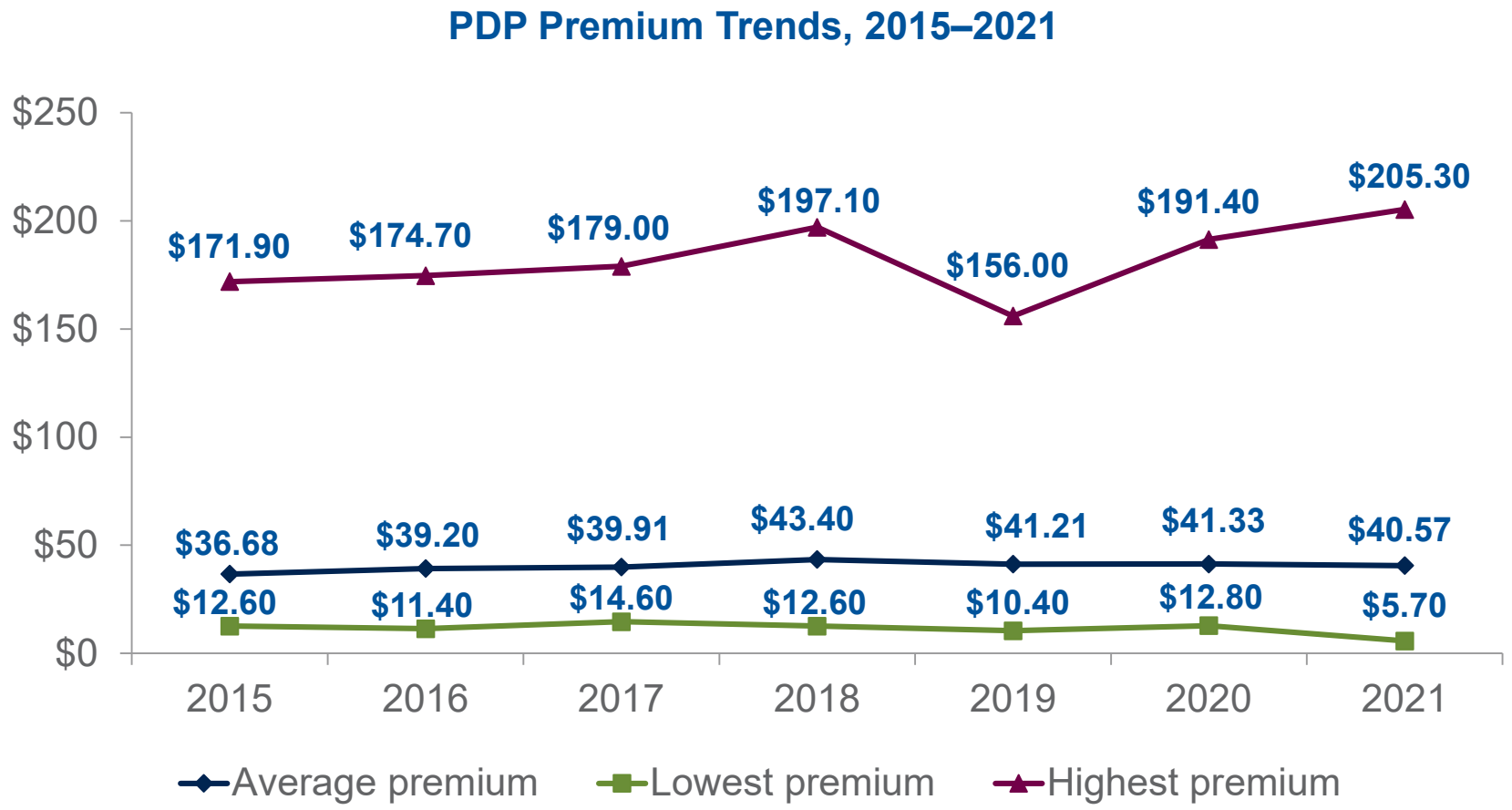
PDP enrollees, on average, have 29 PDPs available to them in 2021




Source: Xcenda analysis of the PDP and MA landscape files from 2015 to 2021.

# PDP premium trends

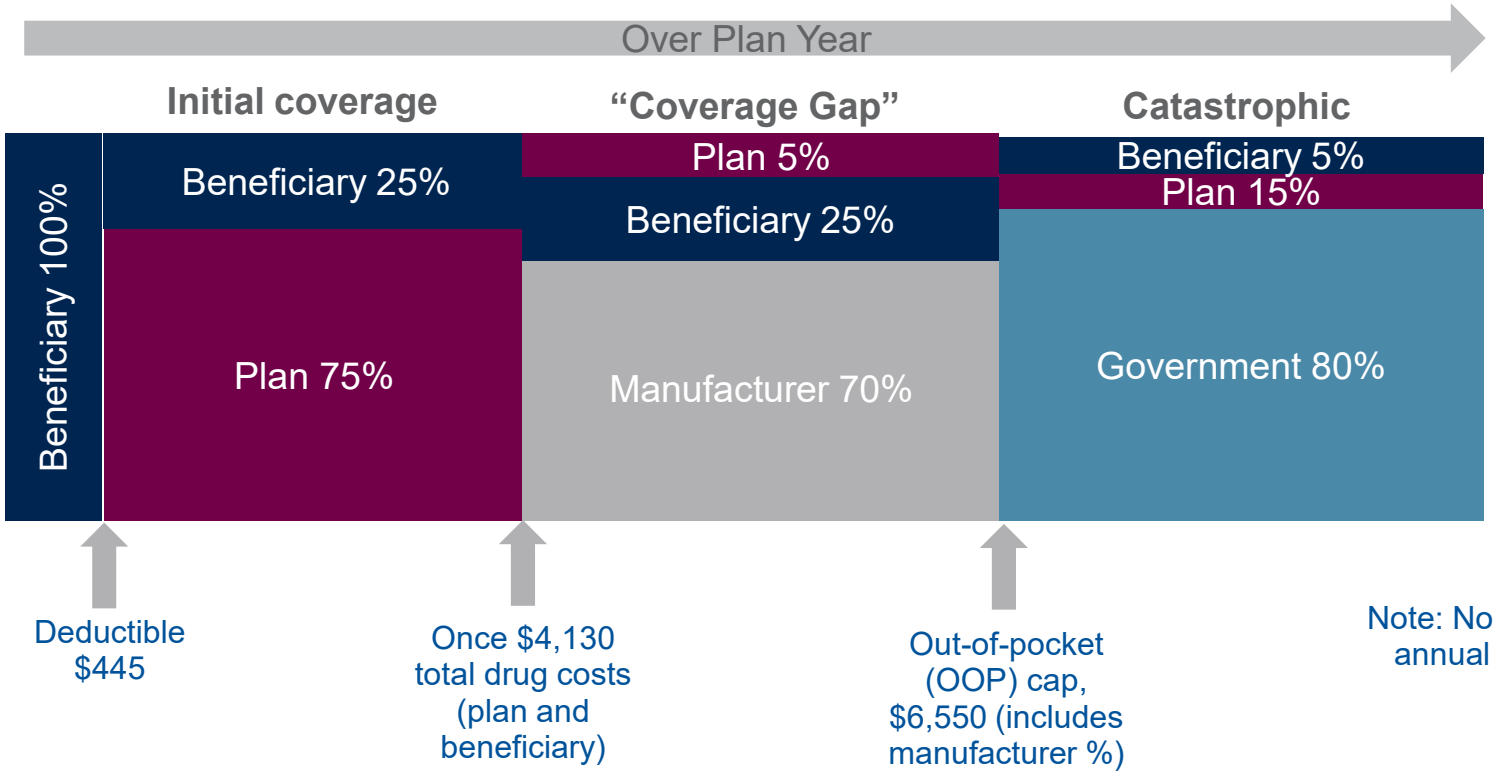
Monthly premiums for PDPs, on average, will remain relatively similar to 2020




Source: Xcenda analysis of the PDP and MA landscape files from 2015 to 2021.

# Standard Medicare prescription drug benefit

Three phases of the benefit, each shifts cost-sharing around to the different stakeholders




Based on 2021 Announcement of Calendar Year 2021 Medicare Advantage Capitation Rates and Part C and Part D Payment Policies.

# Part D plan cost-sharing in 2021

Part D plan cost-sharing at preferred pharmacies, on average, is generally more affordable compared to cost sharing at non-preferred pharmacies (excluding specialty tiers)

| 2021 Cost-Sharing by Part D Plan Type | | | | |
|---|---|---|---|---|
| | PDPs | | MA-PD Plans | |
| | Preferred | Non-Preferred | Preferred | Non-Preferred |
| Preferred generics | $1 | $10 | $2 | $7 |
| Nonpreferred generics | $5 | $15 | $8 | $15 |
| Preferred brands | $40 | $46 | $43 | $46 |
| Nonpreferred drugs | 42% | 45% | $96 | $98 |
| Specialty tier | 27% | 27% | 31% | 31% |

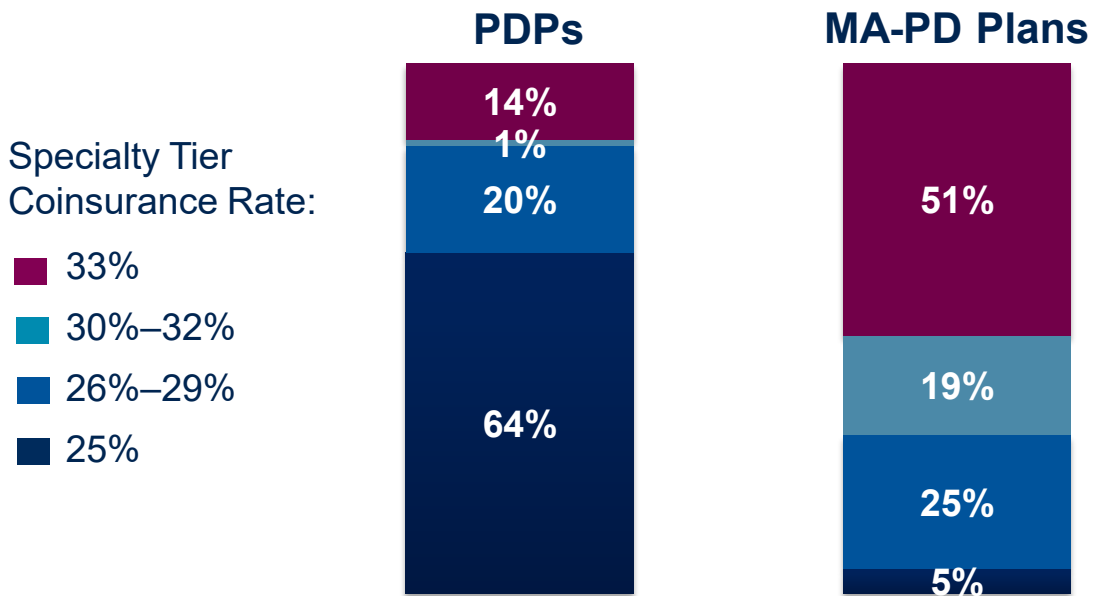
While PDP and MA-PD plan cost-sharing for the most common formulary type is comparable for most products, the plan types generally differ in the cost-sharing type for nonpreferred drugs.

Source: Xcenda analysis of the October 2020 Public Use File for the 2021 Part D plan year.
Note: Xcenda identified the nonpreferred brand or drug tiers based on the most common formulary design in the 2021 file.

# Specialty tier cost-sharing trends

A majority of PDPs require a 25% coinsurance and over 50% of MA-PD plans require a 33% coinsurance for covered specialty medications

## Estimated Distribution of Enrollment in Part D Plans With Specialty Tiers, by PDP and MA-PD Plan

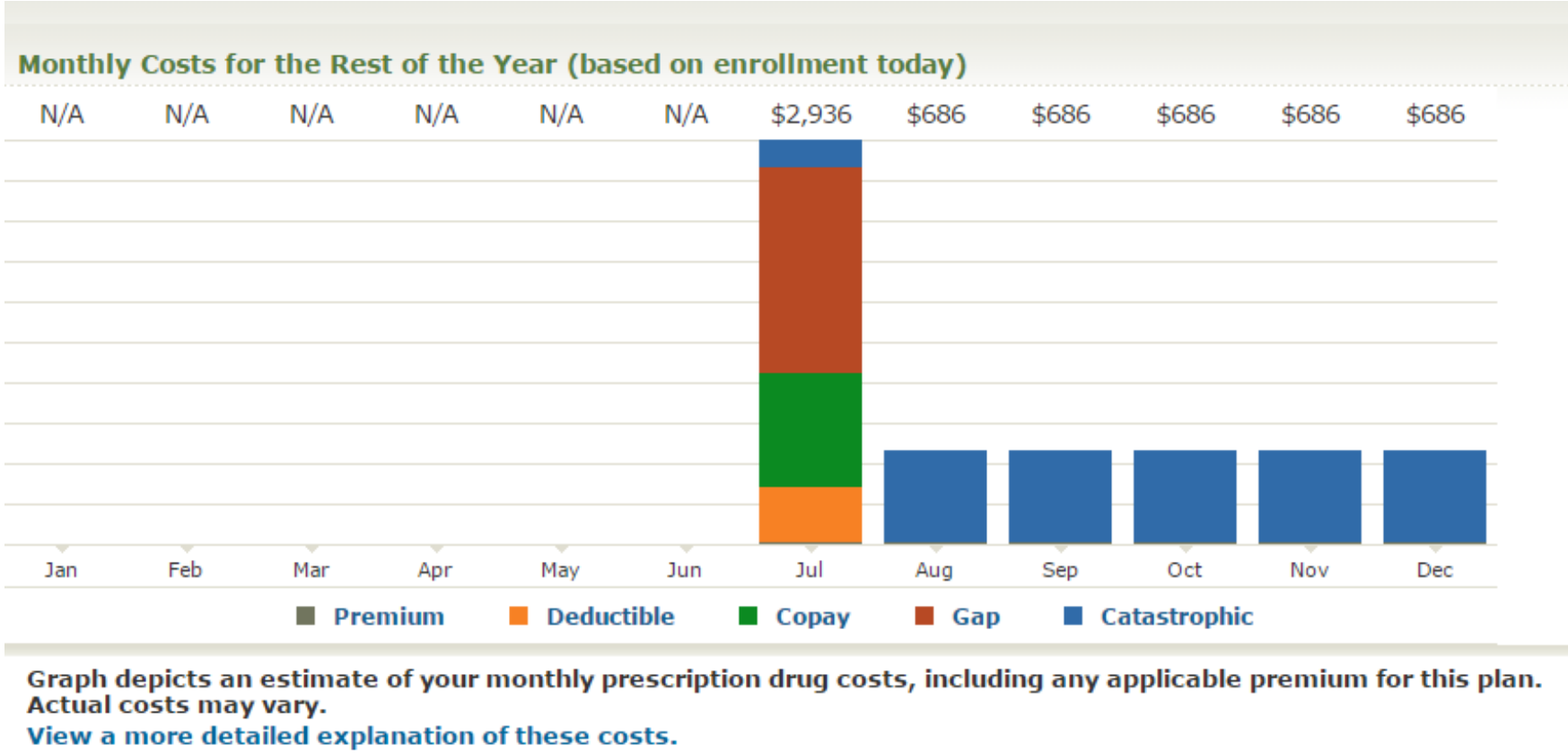



Cost-sharing for high-cost medications can result in significant out-of-pocket costs during the initial coverage phase, especially since products on specialty tiers are prohibited from tiering exceptions

Source: Xcenda analysis of the October 2020 Public Use File for the 2021 Part D plan year.

# Example of specialty tier spending

High-cost specialty tier products can result in beneficiaries hitting the catastrophic phase after 1 treatment




Source: Medicare.gov website.

# Overview of Part D beneficiary financial protections

While Part D enrollees may face OOP costs, there are some protections that have limited the financial burden for select enrollees

## Part D Benefit Design

Catastrophic phase only requires 5% coinsurance for branded drugs for non-low-income subsidy (LIS) beneficiaries after reaching the OOP threshold

## Low-income Subsidy

LIS offers assistance with OOP expenses for eligible beneficiaries

- No or reduced premiums
- No or reduced deductibles
- No or reduced cost-sharing in the initial coverage phase
- No or limited cost-sharing in the coverage gap
- No or reduced cost-sharing during catastrophic phase

## Coverage Gap Closure

- Part D coverage gap was fully closed by 2019
- Branded products are largely financed by manufacturer discount payments in coverage gap

# Proposals to limit OOP costs and "smooth" cost sharing over the plan year

| Legislation | Annual out-of-pocket (OOP) cap | Smoothing mechanism |
|---|---|---|
| **H.R. 3 (2021)** | $2,000 | Allows certain beneficiaries who meet the $2,000 OOP cap in their first fill to pay their costs in periodic installments over the plan year |
| **Revised Senate Finance Drug Pricing Bill (PDPRA) (2020)** | $3,100 | • Caps the amount a Part D beneficiary is required to pay in cost sharing in any one month<br>• Uses a formula to set the smoothing amount, which may vary depending on when the enrollee reaches the catastrophic phase |
| **House GOP Drug Pricing Bill (H.R. 19) (2021)** | $3,100 | Allows beneficiaries who incur a "significant percentage" of cost sharing over a 30-day period to smooth their payments over the plan year |
| **Senate Part D Redesign Bill Released (7/2021)** | As defined under current law at the time of the cost smoothing | Allows beneficiaries whose monthly OOP costs equal or exceed a "significant percentage" of the annual OOP cap to pay down their costs in installments over the plan year |

# Thank you

**Corey Ford**
Director
Reimbursement & Policy Insights

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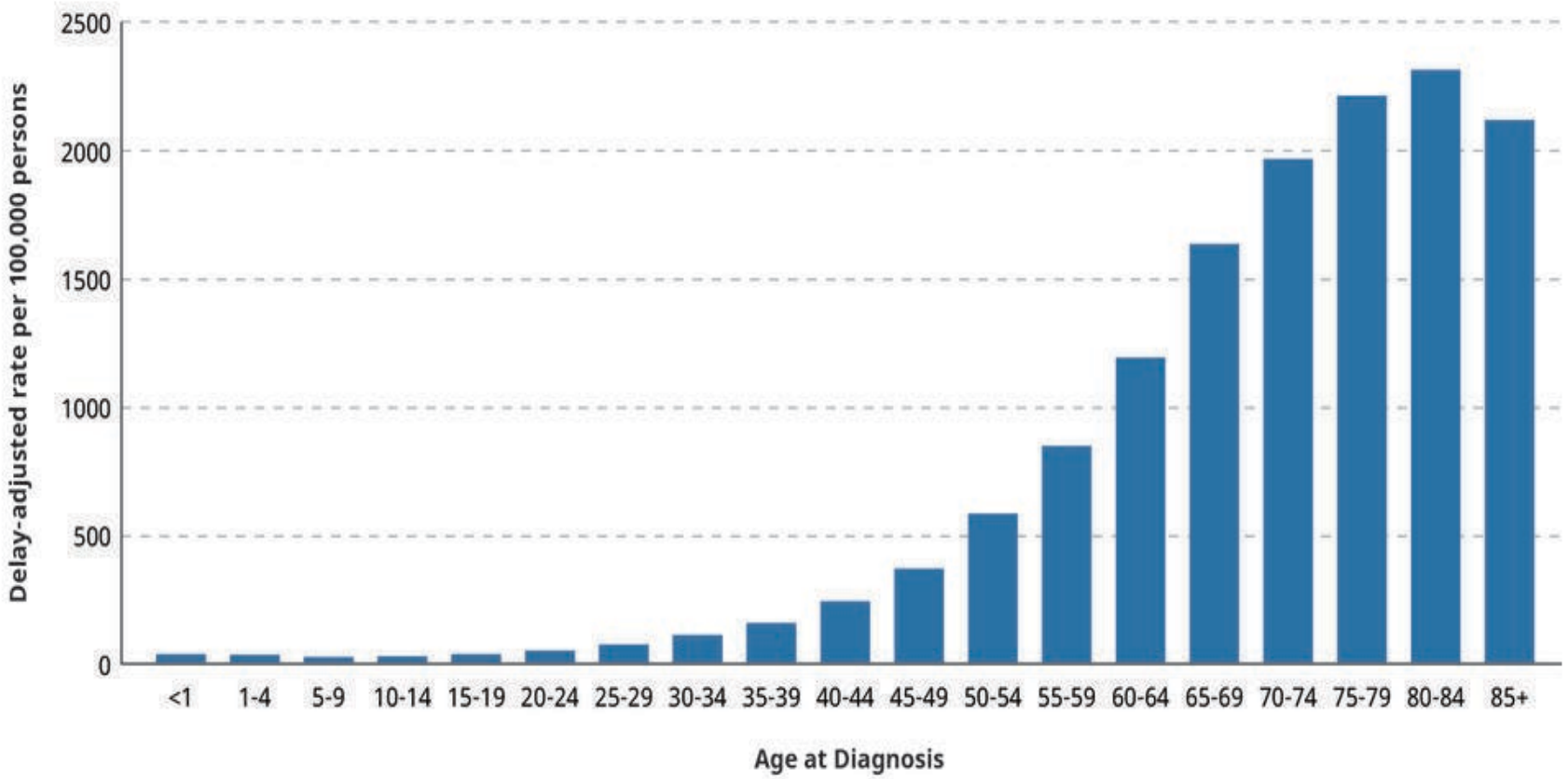
# Illy Jaffer

## *American Cancer Society Cancer Action Network*

# Medicare Part D: Cap on Out-Of-Pocket Costs

**Illy Jaffer**
**Director of Federal Relations**

# Incidence of Cancer Increases with Age




Incidence rates by age at diagnosis, all cancer types. Source: SEER 21 2013–2017, all races, both sexes.
Credit: National Cancer Institute

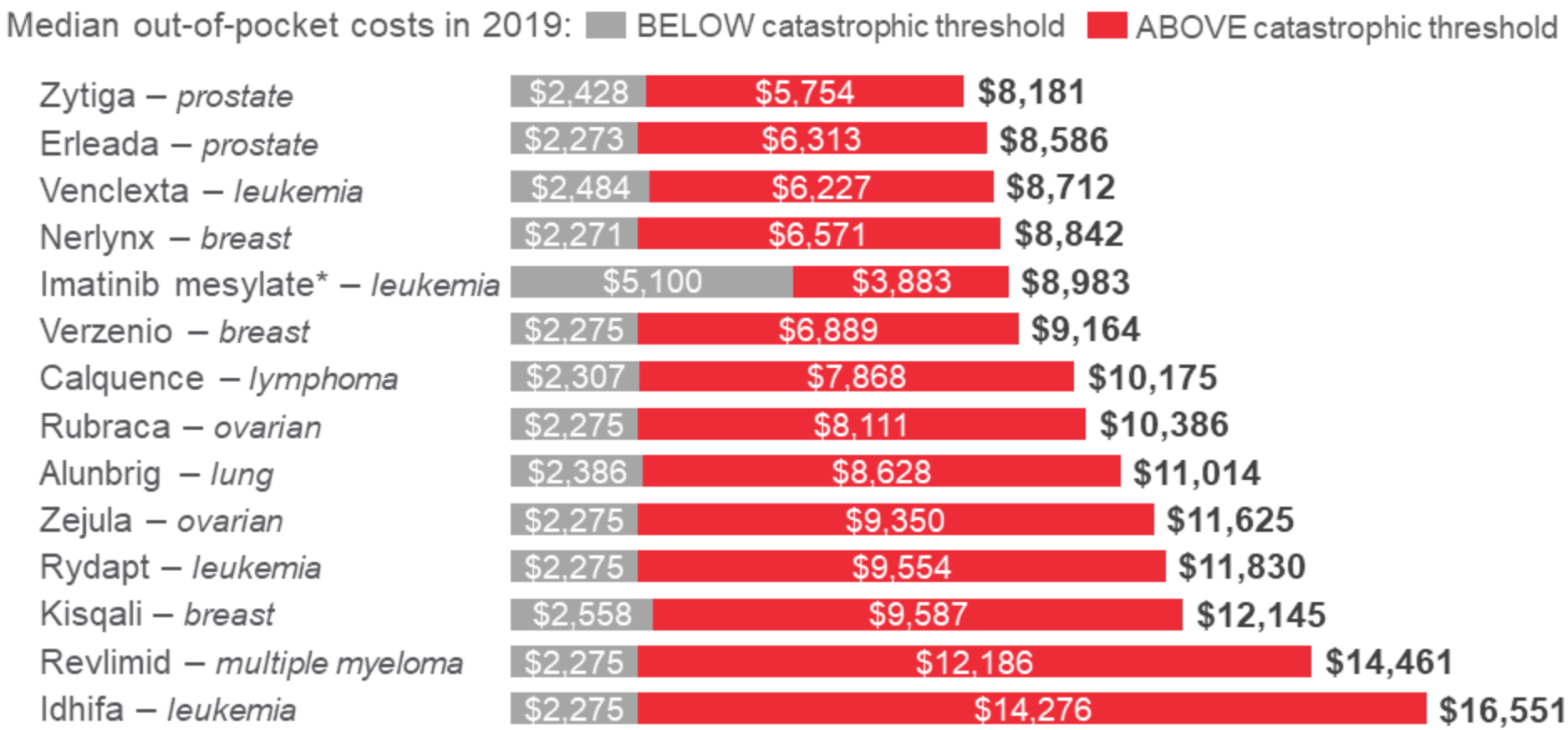
Cancer Action Network℠
American Cancer Society®
20 YEARS

# Cancer Drugs

- Oral cancer drugs can be expensive, costing thousands of dollars per month
- As of 2017, half of all Medicare beneficiaries had annual incomes below $26,200.
- 2019 Kaiser Family Foundation Report on specialty tiers:
  - OOP cost-sharing higher for cancer drugs than any other health condition
  - Median annual OOP cost for drugs studied was more than $8,000

Figure 2

# Out-of-pocket costs for Part D enrollees for selected cancer medications can exceed $8,000, with most of this spending above the catastrophic threshold

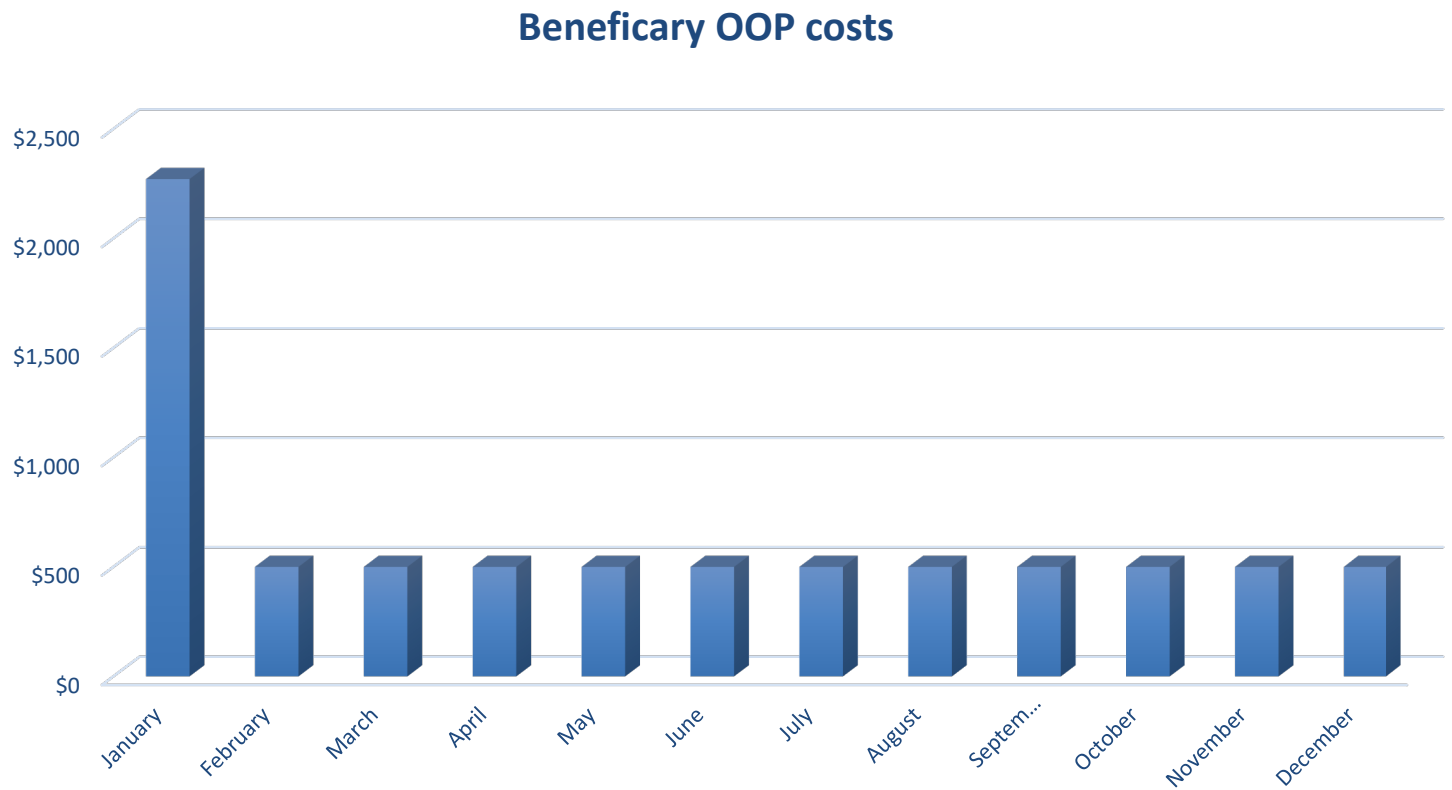



NOTE: Analysis reflects coverage and costs in 25 stand-alone prescription drug plans (mostly national/near-national), based on a pharmacy located in zip code 21201 (Baltimore, MD). *Imatinib mesylate is the generic equivalent of Gleevec, which is not covered by any plan in the analysis and has a median total cost of $145,769.
SOURCE: KFF analysis of 2019 Medicare Plan Finder data.

KFF
HENRY J KAISER FAMILY FOUNDATION

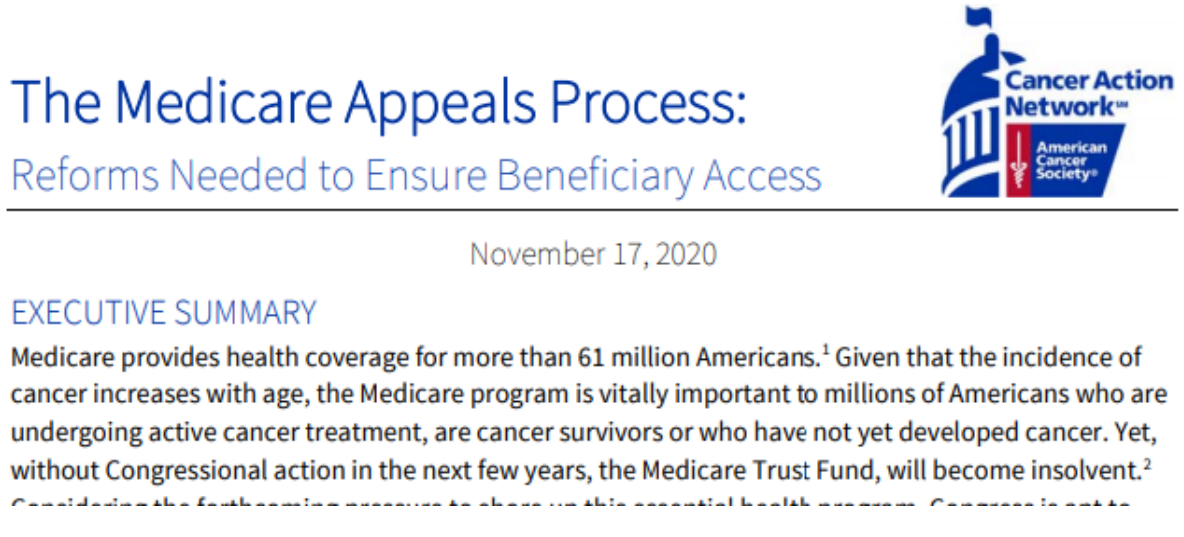
# Beneficiary

Hypothetical example of one brand name drug costing $10,000/month



# Medicare Appeals Project

- ACS CAN report detailing Medicare appeals process across all parts of Medicare



The Medicare Appeals Process:

Reforms Needed to Ensure Beneficiary Access

November 17, 2020

EXECUTIVE SUMMARY

Medicare provides health coverage for more than 61 million Americans.[1] Given that the incidence of cancer increases with age, the Medicare program is vitally important to millions of Americans who are undergoing active cancer treatment, are cancer survivors or who have not yet developed cancer. Yet, without Congressional action in the next few years, the Medicare Trust Fund, will become insolvent.[2]

https://www.fightcancer.org/policy-resources/medicare-appeals-process-reforms-needed-ensure-beneficiary-access

# Thank you!

Illy Jaffer
Illy.Jaffer@cancer.org

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# Bari Talente

## *National Multiple Sclerosis Society*

National Multiple Sclerosis Society

75 YEARS OF PROGRESS

# MapRx Briefing: Medicare Part D Out-of-Pocket Costs

Bari Talente

EVP, Advocacy and Healthcare Access

July 22, 2021

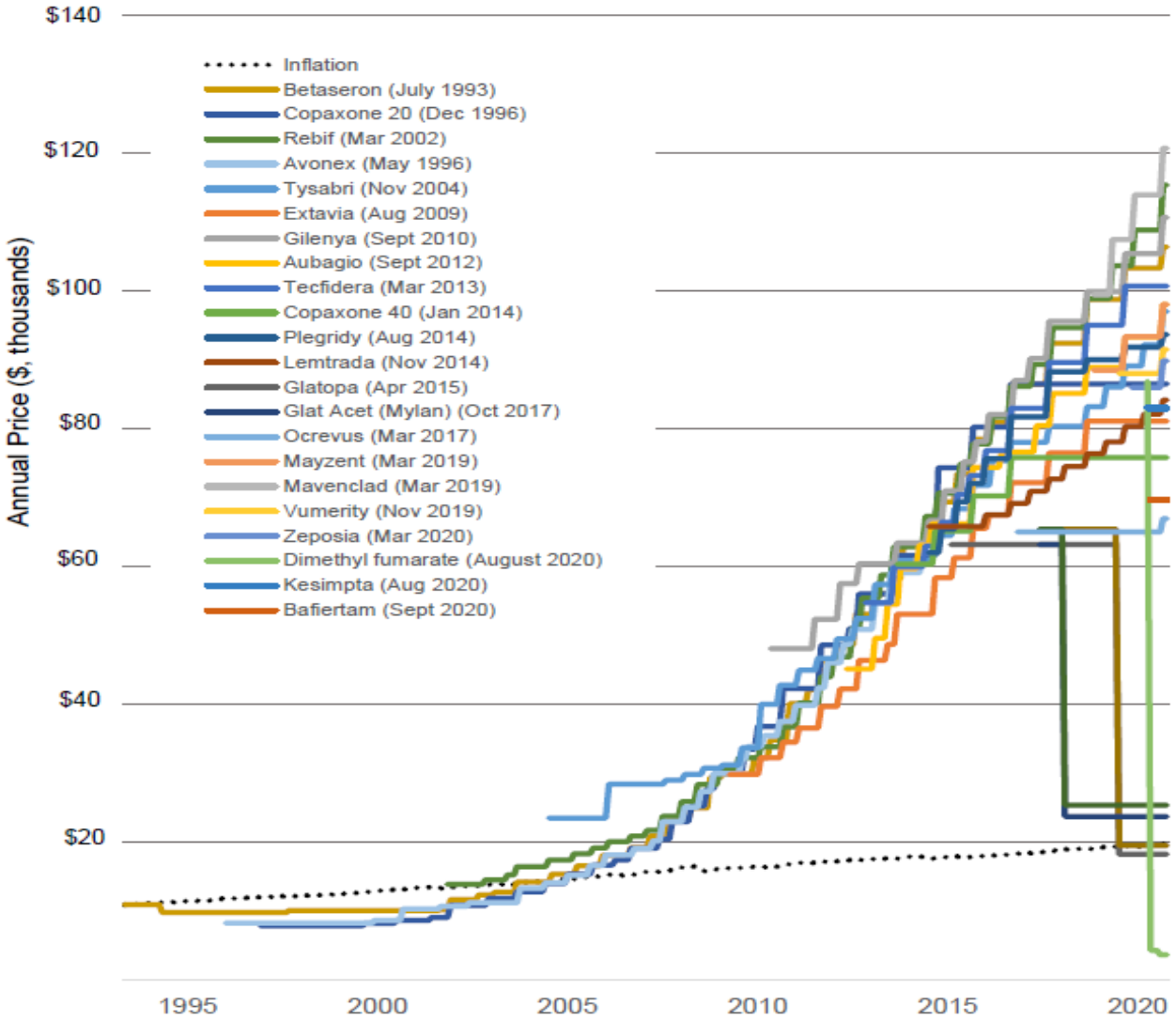
# What is Multiple Sclerosis (MS)?

- MS is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body.
- Symptoms vary from person to person and range from numbness and tingling, to walking difficulties, fatigue, dizziness, pain, depression, blindness and paralysis.
- Nearly one million Americans live with MS.

# MS Treatment

- Disease modifying treatments (DMTs) are the best way to manage the MS disease course, prevent accumulation of disability and protect the brain from damage due to MS.
- DMTs should be started as soon as possible after diagnosis and most must be taken continuously.
- For people with MS on DMTs, 75% of total MS-related health costs are for DMT drugs
- In addition to DMTs, individuals living with MS take often take symptom management treatments.

## Trends in annual price for disease-modifying therapies for multiple sclerosis; 1997 to 2021

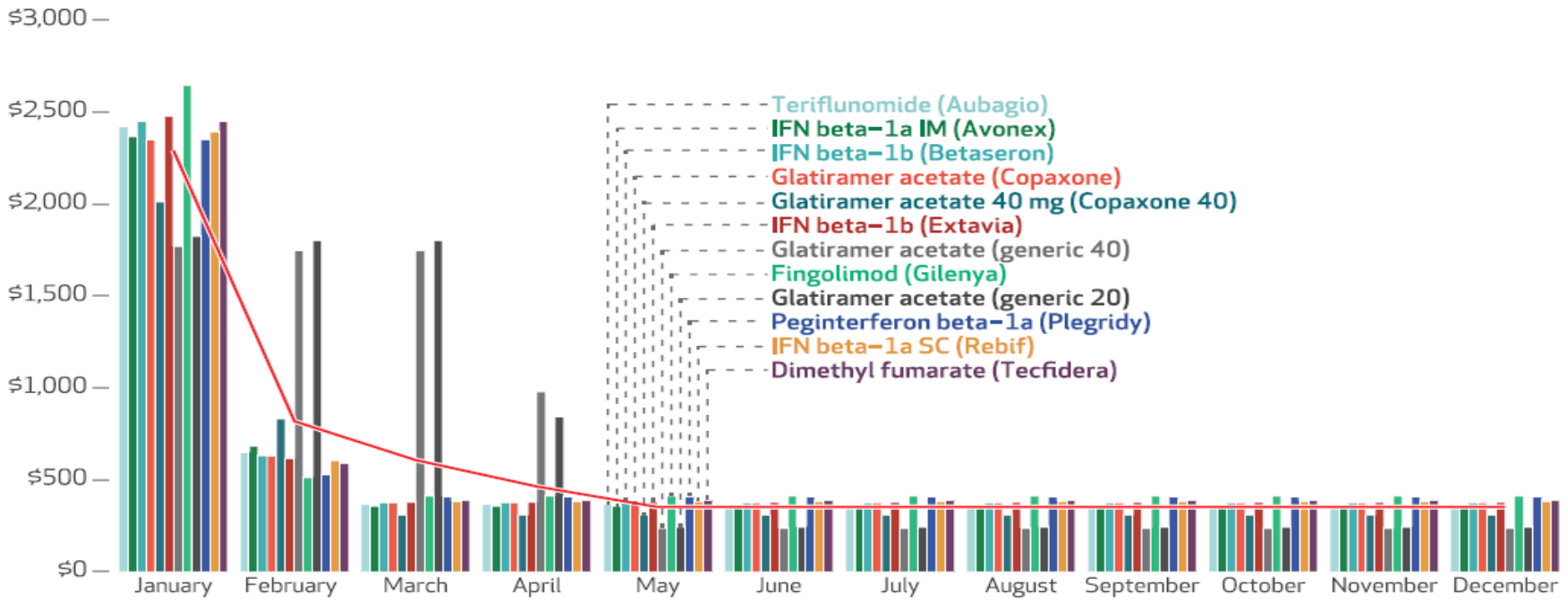



| Drug | 5 Year Change* | 1 Year Change** | Annual Price 2021 |
|---|---|---|---|
| **Self-administered injections** | | | |
| Betaseron | 35.6% | 3.0% | $106,401 |
| Avonex | 30.0% | 2.0% | $93,672 |
| Rebif | 48.3% | 11.3% | $115,359 |
| Extavia | 23.7% | 0.0% | $81,079 |
| Plegridy | 30.0% | 2.0% | $93,672 |
| Kesimpta | | | $83,000 |
| **Glatiramer Acetate** | | | |
| Copaxone 20 | 7.9% | 0.0% | $86,554 |
| Copaxone 40 | 7.9% | 0.0% | $75,816 |
| Glatopa | -71.1% | 0.0% | $18,250 |
| Glatopa 40 | | 0.0% | $19,500 |
| Glat Acet (Mylan) | | 0.0% | $23,725 |
| Glat Acet 40 (Mylan) | | 0.0% | $25,350 |
| **Oral DMTs** | | | |
| Gilenya | 41.6% | 5.0% | $110,660 |
| Aubagio | 31.8% | 5.1% | $98,054 |
| Tecfidera | 37.6% | 0.0% | $100,690 |
| Mayzent | | 5.0% | $98,036 |
| Mavenclad | | 12.4% | $120,742 |
| Vumerity | | 4.0% | $91,520 |
| Zeposia | | 4.5% | $89,870 |
| Bafiertam | | | $69,770 |
| Dimethyl fumarate*** | | | $3,650 |
| **Infusions** | | | |
| Tysabri | 35.2% | 8.9% | $97,032 |
| Lemtrada | 27.9% | 4.8% | $84,168 |
| Ocrevus | | 3.0% | $66,950 |

Notes: Annual price estimated from wholesale acquisition costs (First Databank)
Market entrance date in parenthesis
Dashed line is projected annual price of Betaseron assuming only inflationary increases in price (CPI)
Lemtrada is based on four 12 mg vials (Package insert dosing: 12 mg/day (5 vials) for five consecutive days in first year; 12 mg/day (3 vials) for three days in year 2);
*2016 to 2021 (Februrary); **2020 to 2021 (Februrary), ***lowest price dimethyl fumarate reported
Updated 2.18.2021 (Data through February 2021)

**EXHIBIT 4**

**Projected out-of-pocket spending for beneficiaries without a low-income subsidy for multiple sclerosis disease-modifying therapies, by month, 2019**




**SOURCE** Authors' analysis of data from the Prescription Drug Plan Formulary files of the Centers for Medicare and Medicaid Services (CMS), and CMS enrollment data in 2016 (the most recent data available); and 2019 basic Part D benefit plan parameters. Drug prices are derived from the Medicare Plan Finder, using the nationwide plan that reported the lowest retail costs in the Portland, Oregon, metropolitan area. **NOTES** The solid line is average projected out-of-pocket spending across drugs. Appendix exhibit A6 shows details by drug (see note 20 in text). IFN is interferon. SC is subcutaneous. IM is intramuscular.

Hartung DM. Trends In Coverage For Disease-Modifying Therapies For Multiple Sclerosis in Medicare Part D. Health Affairs. February 2019. doi:10.1377/hlthaff.2018.05357

I didn't ask for this disease. Why should we, **as people who worked all our lives, pay so much for medicine when we're on a fixed income** and you know that we can't pay for it?

**Ms. Dixon**, Ohio
Diagnosed with MS in 1998

Legislators, pharmaceutical companies and insurance companies **need to work together to come up with the solution** to make medications more affordable for people living with MS.

**Holly,** New Mexico
Diagnosed with MS in 2011

**I want Congress to do something** about the high cost of prescription medication in the U.S.

**Marcus,** California
Diagnosed with MS in 2010

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# Howard Bedlin

## *National Council on Aging*

national council on aging

# Medicare Part D

## The Beneficiary Perspective

**Howard Bedlin**

*Government Affairs and Advocacy Principal*

July 22, 2021

# Who we are

| | |
|---|---|
| **Vision** | A just and caring society in which each of us, as we age, lives with dignity, purpose, and security |
| **Mission** | Improve the lives of millions of older adults, especially those who are struggling |
| **Goal** | Impact the health and economic security of 40 million older adults by 2030, especially women, people of color, LGBTQ+, rural, and low-income individuals |

# Where we've been

## 1950 – 1970

**National Council on Aging** formed

Study leads to creation of **Meals on Wheels**

Advocacy leads to **Medicare**, **Medicaid**, Older Americans Act, and Age Discrimination in Employment Act

Among the first in the nation to pilot the **Senior Community Service Employment Program**

## 1971 – 2000

Advocacy leads to **elimination of mandatory retirement**

**BenefitsCheckUp** is nation's newest and most comprehensive online benefits screening tool

National Institute of **Senior Centers** brings best practices to local organizations

## 2001 – Present

Advocacy leads to **Medicare Part D** and **benefits outreach** for low-income individuals

**SNAP Initiative** connects older adults to food benefits

**Evidence Based Health Aging**, including **Falls Free Initiative** which drives action to reduce falls

**My Medicare Matters**, **Age Well Planner**, and **Aging Mastery Program** provide new tools to navigate aging

# 4 Areas for Discussion

1. Improving access to Extra Help/Low-Income Subsidy (LIS)
2. Improving Part D Appeals
3. Improving Beneficiary Education and Decision-Making
4. Covering Obesity Drugs

# Part D Extra Help/Low-Income Subsidy

## The Facts

- Premium and cost-sharing assistance is available for individual enrollees with incomes below 150% of poverty ($19,320) and assets below $14,790.
- Less generous help is available for those with incomes between 135-150% of poverty, with high 15% coinsurance rates.
- Median per capita income and assets for white beneficiaries are substantially higher than for Black and Hispanic beneficiaries, and almost 70% of low-income beneficiaries age 65+ are women.
- The asset test penalizes retirees who did the right thing during their working years by setting aside a modest nest egg of savings to use in case of emergencies.
- Medicaid expansion states provide low-income assistance without an asset test.

# Part D Extra Help/Low-Income Subsidy

## Legislative Proposals

- Sen. Casey bill (S. 1844) would eliminate asset test and raise income eligibility thresholds to 200% of poverty.
- The 2019 House H.R. 3 bill would:
  - Eliminate the partial LIS benefit and make full benefits available to those with incomes up to 150% of poverty – H.R. 3 Section 503. Bill this year – H.R. 2464, Rep. Angie Craig.
  - Exclude disbursements from retirement plans from income test – H.R. 3 Section 506. Bill this year – H.R. 3831, Rep. Susie Lee.

# Part D Extra Help/Low-Income Subsidy

## Additional Incremental LIS Improvements

- Eliminate cost sharing for generic drugs
- Simplify application forms and make them available in at least three additional commonly spoken languages
- Examine alternatives to random assignment when enrollee' plan loses benchmark zero premium status
- Send notices about switching plans to all LIS enrollees with premium liability

# Improving Part D Appeals

## Appeals and Denials

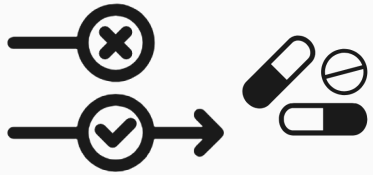
- The current appeals process is confusing and burdensome for beneficiaries.
- A denial at the pharmacy DOES NOT count as a coverage determination - which is needed to request an appeal.
- The reason for the denial is often not provided and requires beneficiaries to contact their plan and then work with their doctor to determine the best path forward.
- Less than 5% of denials at the point of service lead to a request for a coverage determination, despite high reversal rates.

# Improving Part D Appeals

## Appeals and Reforms

- The current appeals process can lead to delays in access to needed medications, reduced adherence and higher costs.
- Legislation is needed to improve information, transparency and notice at the point of sale and allow a pharmacy denial to function as an initial coverage determination.
- The 2019 bipartisan, bicameral Streamlining Part D Appeals Process Act would help ensure that beneficiaries can better access, understand, and manage the Part D appeals process.

# Specialty Tier Exceptions



In general, beneficiaries may file an exception for a drug to be placed on a lower cost-sharing formulary tier - except for specialty tier drugs.

This exception has no clear statutory authorization.

Failing to permit specialty tier exceptions impacts beneficiary access and affordability, especially those with conditions that have limited treatment options.

# Beneficiary Education and Decision Supports

## Supports and Improvements

- Choosing the right Part D plan is often confusing, with beneficiaries making choices that can increase out-of-pocket costs and limit access to needed drugs.
- Additional improvements to the Medicare Plan Finder tool are needed.
- More can be done to improve health insurance literacy, promoting better understanding of terms and concepts like formularies, tiers, preferred pharmacies, and the difference between copayments and coinsurance.
- Additional funding is needed for Medicare State Health Insurance Assistance Programs (SHIPs).

# Coverage of Obesity Drugs

## The Facts

- In 2013, the American Medical Association recognized obesity as a complex, chronic disease that requires support to prevent and treat it.
- According to the CDC, obesity increases the risk for heart disease, stroke, and diabetes
- Obesity increases the risk and severity of COVID-19. Seventy-nine percent of patients hospitalized with COVID-19 were overweight or had obesity, which is also linked to greater risk for ICU admission and death.
- The burden and cost of obesity is particularly pronounced among communities of color. Approximately 50%  of Blacks and 45% of Hispanics suffer from obesity.

# Coverage of Obesity Drugs

## The Problem

- Anti-obesity medications are not covered by Medicare. These medications are increasingly recognized as an effective option for some individuals, especially those who carry significant excess weight and have not been able to lose weight through lifestyle and dietary changes.
- Lack of coverage limits treatment choices and creates a gap in the continuum of care, which can pose particular challenges for low-income beneficiaries.
- Including FDA-approved medications in Medicare Part D coverage would help reduce health disparities, lower COVID-19 risk factors and the incidence of many chronic diseases associated with obesity and could result in long-term cost savings.

# How can we work together?

**Howard Bedlin**
Government Affairs and Advocacy Principal

howard.bedlin@ncoa.org

**National Council on Aging**
*Improving the lives of millions of older adults*
251 18th Street South, Suite 500
Arlington, VA 22202
ncoa.org | @NCOAging