PAN Foundation

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Patient Access Network Foundation Public Comments

Advisory Panel on Outreach and Education
April 18, 2024

On behalf of the Patient Access Network (PAN) Foundation (PAN Foundation), I am providing public comment on the importance of outreach and education on Medicare reforms enacted through the Inflation Reduction Act signed into law August of 2022. My name is Amy Niles, the Chief Mission Officer at the PAN Foundation. The PAN Foundation is a national patient advocacy organization and charitable foundation that for two decades, has been dedicated to helping underinsured people living with life-threatening, chronic, and rare diseases get the medications and treatments they need by assisting with their out-of-pocket costs. Additionally, through our national and grassroots efforts, we advocate for improved affordability and access to care. Since 2004, we have provided more than 1.1 million underinsured individuals with $4 billion in financial assistance.

Two critical Medicare reforms go into effect January 1, 2025: the Medicare Part D $2,000 cap on out-of-pocket expenses for prescription medications, and the Medicare Prescription Payment Plan, that allows Part D plan enrollees to smooth out their out-of-pocket expenses throughout the year.

Both the $2,000 cap and the ability to smooth out the payments throughout the plan year will have a significant impact on Medicare beneficiaries, especially those who experience high drug costs. The Department of Health and Human Services (HHS) estimates that in 2025, 36 percent - or 18.7 million - Medicare Part D enrollees will see savings in out-of-pocket costs of about $400 as a result of these reforms. However, there is a subset of enrollees – 1.9 million – that will have an average annual out-of-pocket savings of about $2,500 per enrollee.[1] These are likely individuals who are living with serious illnesses and depend on life-saving high-cost medications. The ability to smooth out-of-pocket expenses throughout the year, combined with the Part D cap of $2,000, increases affordability for those with high cost sharing early in the year and lessons abandonment of medications not only at the beginning of the year when deductibles reset, but throughout the benefit year.

The Medicare Prescription Payment Plan is operationally quite complex. A key challenge in taking advantage of the Medicare Prescription Payment Plan is that those enrolled in prescription drug plans – either Part D plans or Medicare Advantage plans – must opt into the program. It is a strictly voluntary program. CMS guidance issued to date makes clear that those most likely to benefit should opt-in prior to the start of the new plan year. This would ensure that when filling the first prescription of the year, “smoothing” will be in place and the beneficiary will pay nothing at the pharmacy counter. Instead, they will be billed later by their plan in monthly installments. In turn, the pharmacy will receive the full copay from the plan once the medication is dispensed.

Broad and far-reaching education and outreach about the Medicare Prescription Payment Plan will be critical so that those enrolled in prescription drug plans are made aware of this option. CMS will be making changes to their materials (e.g., Medicare Part D documents, website content, tools) before the plan year begins. CMS seeks to make sure that Part D sponsors, pharmacies, providers, and beneficiary advocates will have what they need to inform individuals about the new optional program.

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While CMS and the plans are required to provide information on the Medicare Prescription Payment Plan, particularly to those most likely to benefit, we and others in the patient advocacy community remain concerned that this outreach and education may be insufficient.

As part of its education and outreach, it will be important to make clear that the Medicare Prescription Payment Plan is a new government-mandated program requiring Part D plans to offer the opportunity to enrollees to spread their out-of-pocket costs on a monthly basis. It is not a new offering from their prescription drug plan with an associated cost.

We have additional recommendations, all of which have been shared with CMS. Among our recommendations:

- Enrollees who opt-in to the Medicare Prescription Payment Plan may experience variation from month to month in what they will be required to pay their plan, based on their prescription drug needs. It will be important for enrollees to understand that despite this variation, they will not pay more than $2,000 in total for all of 2025 for their prescription medications.
- All communications should be easy-to-understand and in multiple languages.
- We are concerned that CMS has set an out-of-pocket threshold of $600 for a single prescription to identify enrollees who are likely to benefit and therefore will receive a “Likely to Benefit Notice” from the plan and at the pharmacy counter. We believe the threshold is far too limiting and should be based on cumulative costs rather than a single prescription.
- CMS will be targeting providers with information based on their likelihood of prescribing high cost covered drugs. We believe this could leave out providers that Part D enrollees trust for drug related information.

We appreciate 2025 will be the first year of implementation of the Medicare Prescription Payment Plan and we expect it to have challenges. We will be working to educate our patient and provider communities about this program to ensure a smooth roll out and will continue to work with CMS to lift up lessons learned to make improvements for the following plan year.

In closing, I’d like touch on another important federal program that assists individuals with low-income afford their medications – the Low-Income Subsidy or “Extra Help” program The program began in January of 2006 and CMS estimates that up to 3 million people who are eligible for the program are not enrolled.[2] This is due in part to the lack of awareness about the program as well as the complexity of applying for those who are not dual-eligibles and auto-enrolled. We are grateful that beginning January 1, 2024, the LIS program was simplified in terms of eligibility by eliminating the partial subsidy and providing full benefits to those up to 150% of the federal poverty level.

We urge CMS to conduct more outreach and education to those most likely to be eligible for LIS so that they too can afford their needed medications.

Thank you again for your time and attention to these important matters.

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[1] https://aspe.hhs.gov/sites/default/files/documents/1b652899fb99dd7e6e0edebbcc917cc8/aspe-part-d-oop.pdf
[2] https://www.hhs.gov/about/news/2023/06/12/fact-sheet-biden-harris-administration-announces-new-tools-lower-prescription-drug-costs-low-income-seniors-people-disabilities.html