

February 7, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure,

On behalf of the undersigned organizations, we write to thank the Biden Administration for supporting the expansion of full Medicare Part D Low-Income Subsidy (LIS, or “Extra Help”) benefits up to 150 percent of the poverty level in the Inflation Reduction Act (IRA, [PL 117-169](#)). We laud your leadership in seeking to improve access to prescription drugs for Medicare beneficiaries with Part D coverage. For many, the LIS program is a critical safety net that helps cover out-of-pocket costs for prescription drugs. We also thank CMS’s proposal to codify into rulemaking this provision of the IRA as well as its proposal to codify into rulemaking the provision of the 2020 Consolidated Appropriations Act, which makes the LINET program permanent, both of which will come into effect in January 2024.

Prior to the implementation of the IRA / “new prescription drug law” LIS expansion in 2024, we urge CMS to consult with stakeholders on opportunities to educate more people about this shift, and to consider options, some of which are outlined below, to strengthen the program’s effectiveness for beneficiaries. LIS has helped make prescription drugs more affordable for millions of low-income beneficiaries with about [13 million](#) Part D enrollees (27 percent) participating in 2021. The complex application and renewal processes and lack of awareness about the program, coupled with market instability, however, has led to challenges in terms of participation rates, plan churn, and transitions between plans for LIS enrollees.

The LIS program, which the Social Security Administration (SSA) currently estimates saves beneficiaries an average of \$5,300 a year, plays an important role in advancing health equity—a central pillar of the CMS strategic plan. A pre-pandemic ASPE [report](#) revealed that, among adults 65 and older, Black and Latino Medicare beneficiaries were roughly one and a half to two times more likely to experience affordability challenges than white beneficiaries and two times as likely not to get needed prescriptions due to costs. In terms of income, about [63 percent and 68 percent](#) of Medicare-eligible Black and Latino adults, respectively, have family incomes below 200 percent of the Federal Poverty Level — nearly twice as many as older white adults. There is an even wider gap in [average household savings](#) when comparing white to Black or

white to Latino Medicare beneficiaries. Strengthening LIS enrollment could help decrease these stark inequities when it comes to prescription medication access.

As noted above and discussed more fully below, not all eligible beneficiaries receive Extra Help and many experience potentially avoidable disruptions in access to needed medications due to plan changes. Specifically, plan premium increases above the benchmark trigger either increased costs (for those who actively chose their plan) or re-assignment into a random new plan, which can imperil access to needed medications. While designed to be an important safeguard, such a disruption can compromise continuity of care, potentially leading to patient harm. To increase enrollment in this important program, and minimize disruption, we recommend the following:

I. *Understanding the LIS population*

A. *Recommendation: Share estimates on the number of individuals eligible for both the partial- and full-LIS subsidy*

We appreciate the recent [data](#) released by CMS showing how many beneficiaries are enrolled in the LIS programs. Could CMS also share the methodologies and data set used to estimate the number of beneficiaries eligible for full and partial LIS assistance, broken down by geographic region? We recognize that it can be challenging to provide accurate eligibility estimates given that beneficiary asset data is not readily available. However, we believe that the only way to bridge the eligibility versus enrollment gap is to better understand the unenrolled population and then target education and outreach strategies to them. We would be interested in discussing CMS' efforts to reach the LIS unenrolled population and learn more about efforts to address the data short falls. Lastly, we were curious to see the number of partial LIS enrollees decline from 410,245 in 2019 to 312,500 in 2022 and would be interested in learning more about this large decrease.

B. *Recommendation: Coordinate the sharing of cross-Federal agency data on the number and demographic characteristics of Medicare enrollees eligible for but not enrolled in LIS*

To get a better picture of the LIS population, we recommend that CMS collaborate with various Federal agencies to publish the LIS-eligible population's asset and income data together in the Medicare Monthly Enrollment dataset. We would also like to recommend that the agencies disaggregate this data for both full- and partial-LIS beneficiaries by at

least a few demographic categories such as race/ethnicity, gender, income, and age bracket. This will help CMS and organizations like those included below, develop target education and outreach to increase awareness and enrollment.

II. *Improving communication with beneficiaries and providers*

A. *Recommendation: Make an ongoing effort to educate beneficiaries about LIS*

We recommend that any information that discusses the Medicare program also describe how the Part D LIS helps qualifying individuals cover their out-of-pocket drug costs. Organizations that have signed onto this letter continue to educate respective constituencies about the parameters of Medicare and the Extra Help program. Also, we would like to recommend that CMS consider increasing and making permanent Medicare funding for low-income outreach and enrollment efforts, which have been extended 11 times since 2008 under the Medicare Improvements for Patients and Providers Act (MIPPA). We would be happy to discuss with CMS how we can help amplify its messaging on these topics.

We also strongly encourage CMS to include LIS information within communications to Medicare Savings Program (MSP) enrollees. Quite often, low-income beneficiaries identified as potentially eligible for MSPs have incomes and/or assets just above the eligibility thresholds but are within the higher thresholds for LIS eligibility. In these instances, information and assistance with LIS enrollment can be critical. It is imperative that outreach and enrollment efforts are comprehensive and recognize that there may be a range of other important untapped benefits for these eligible individuals.

B. *Recommendation: Simplify application forms and related communications and make them available in additional, commonly spoken languages*

The LIS application process for a non-dual eligible beneficiary is complicated and can be intimidating for non-English speakers, those without internet access and individuals with relatively low levels of literacy. While several of our organizations routinely promote educational resources to help people navigate this challenging and time-consuming process, streamlining the application, making it available in additional languages, and increasing outreach could yield big benefits for low-income enrollees.

We also encourage CMS to make its online LIS information available in languages other than English, and to work with SSA to ensure that SSA's online LIS information and the LIS application are available in several additional languages other than the current English and Spanish.

We also thank CMS for directing beneficiaries in its notices to call 1-800-MEDICARE, not only in English but also in 14 additional languages. We recognize the value that these translation services provide. We encourage CMS to continue to invest in the 1-800-Medicare workforce to ensure that it has the necessary language skills to explain something as technically complex as LIS eligibility.

C. *Recommendation:* Send the Chooser's Notice regardless of whether an enrollee has chosen a plan

Printed on tan paper, the LIS Chooser's Notice is sent to LIS-eligible individuals who meet the below criteria. The communication was sent to [483,558 individuals in 2021](#).

It is our understanding that the Chooser's Notice goes to:

- Full-subsidy beneficiaries
- Beneficiaries who actively chose their Part D drug plan and were not auto assigned into a plan; and
- Beneficiaries who will be liable for a portion of their plan's premium next year

It is also our understanding that enrollees at one time did not receive the Chooser's Notice if they had at any time in the past chosen their own plan. If this is still the case, we strongly recommend that CMS ensure that the Chooser's Notice goes to anyone meeting the above criteria. It is also our understanding that individuals had not received the notice because CMS assumed the beneficiary would want to stay with the plan even if the enrollee starts paying a premium the next year.

The LIS population is especially cost sensitive. NCOA's 2019 review of the population of individuals receiving the Chooser's Notice found that this group paid an average of about \$24 a month in premiums the next year because they were not enrolled in available zero-premium plans. For LIS enrollees, \$288 per year can be a significant burden. Too many low-income beneficiaries are paying premiums unnecessarily, some with substantial out-of-pockets costs, and should receive reminders and information on how to save money by switching to lower cost plans.

D. *Recommendation: Make an ongoing effort to educate pharmacists about LINET*

We thank CMS for, per the 2020 Consolidated Appropriations Act, making (and proposing to codify in rulemaking) the Limited Income Newly Eligible Transition (LINET) Program permanent beginning in 2024. We fully support this program and value its contributions to the lives of low-income, Part-D-eligible individuals. LINET provides temporary Part D prescription drug coverage for low-income Medicare beneficiaries not yet entitled to Part D. Yet not all stakeholders are aware of this program and the essential assistance it provides.

NCOA has, for instance, heard from several State Health Insurance Assistance Program (SHIP) counselors, who have highlighted that some pharmacists are unaware of LINET and its eligibility guidelines, which limits access to LIS. We encourage CMS and contractors to regularly educate and communicate with pharmacists about LINET, its eligibility guidelines, and all necessary implementation and operational processes.

E. *Expressing support: CMS's Part D notices and recent updates to them*

We appreciate CMS's use of various notices to let beneficiaries know about several possible changes to their Part D plans. A Part D notice, oftentimes printed on various shades and colors of paper, might highlight higher premiums in the beneficiary's existing plan, opportunities to elect a zero-premium plan, or notify the enrollee they're being moved to a new plan either due to costs or the plan not participating in Part D in the new year.

We would also like to express our appreciation for the [redesigned](#) 2021 Chooser's Notice, which limited the information on the front page of the notice to key takeaways and made the information easier to navigate through the use of headers and bolding. We hope that CMS's making the Chooser's Notice easier to digest will help beneficiaries to read, understand, and take necessary steps to find an appropriate plan for their circumstances.

III. *Improving health access and outcomes and saving beneficiaries money with Beneficiary-Centered Assignment*

Recommendation: Reassign beneficiaries to plans that cover their drugs and include their pharmacy and then communicate with them about the change

As plans move in and out of benchmark status due to annual recalculations of the benchmark and plan premium changes, LIS beneficiaries are often randomly reassigned to new benchmark plans. This random reassignment affected [253,018](#) people in 2021. Printed on blue paper, the LIS Reassignment Notice goes to:

- Full subsidy beneficiaries auto assigned into a plan who, thus, did not choose a plan; and
- Their chosen plan has been, during the current calendar year, under the benchmark and therefore required no monthly premium payment; and
- Their chosen plan's premium is increasing above the benchmark next year, which means they will need to pay a premium.

Extra Help enrollees receive the blue Reassignment Notice more often than those peers not enrolled in LIS. As plans move in and out of benchmark status, the LIS enrollee is randomly reassigned to keep to the benchmark rate. This churn can create uncertainty and can be overwhelming. Furthermore, beneficiaries are not always randomly reassigned to plans that fit their needs. Also, many reassigned beneficiaries see drops in plan quality going from one plan to another. According to one 2013 [study](#), 66 percent of reassigned individuals were moved to plans the authors deemed to be of low quality.

According to one [study](#), CMS has historically used this random reassignment method due to such things as its not wanting to steer beneficiaries to a particular plan. To encourage plans to participate in Part D, the authors write, CMS during the first decade of the benefit also used this method to ensure that, in general, the LIS population with its higher drug utilization would be spread out across plans.

The current landscape is no longer driven by concerns about plan participation in Part D. The older justification for random assignment, we recommend, should be weighed against the adverse patient health and financial outcomes arising from a new plan not covering the reassigned enrollee's essential medicines or from the beneficiary's need to travel to a new, more geographically distant pharmacy that takes the new plan. After all, lower-income individuals are less likely than their wealthier or healthier peers to have the ability or resources to overcome these new barriers.

While we appreciate that CMS's approach to reassignment reduces the number of LIS beneficiaries who pay premiums, we also encourage CMS to study and consider adopting [beneficiary-centered assignment](#). Beneficiary-centered reassignment would reassign beneficiaries to plans that cover their drugs and include their preferred pharmacy. This alternative reassignment method would take beneficiaries' current prescription drug regimens and pharmacies into account in assigning them to new benchmark plans. This is the same logical process that CMS recommends each year for Medicare beneficiaries when it urges them to use the web-based Medicare Plan Finder to determine whether the plan in which they are currently enrolled or an alternative is the optimal plan for them.

We recommend that CMS study the financial and health outcomes associated with random assignment against those associated with beneficiary-centered reassignment and then allow this data to drive its decision making. Until this data is available and studied and until CMS wishes to address the issue, we recommend that CMS consider recommending, in its Reassignment Notice, that the beneficiary review their newly reassigned plan to ensure that their medications are covered and that their preferred pharmacy is in network. CMS may also wish to direct the beneficiary to call their local SHIP office for further guidance.

Additional Considerations

We support legislative solutions to improve access to the Part D LIS, including by removing asset limits that penalize lower-income beneficiaries who were able to set aside modest savings during their working years. We also support using LIS eligibility criteria as a floor for MSP eligibility to simplify enrollment in both programs. We encourage CMS to support such proposals should Congress take legislative action to increase the affordability of medications for more low-income Americans.

Taking administrative action to strengthen the LIS program would have a tremendous impact on the lives of millions of older adults and people with disabilities living on low incomes across the country. We urge CMS to consider implementing these recommendations in concert with implementation of the IRA's LIS expansion.

We appreciate CMS's understanding that some of our data and citations are based on currently available information.

We appreciate your leadership in seeking solutions to increase access to and affordability of healthcare for more Americans. We would welcome an opportunity to speak with you or members of your team about these efforts. If you would like further information or have questions, please contact Amy Niles at aniles@panfoundation.org, Howard Bedlin at Howard.Bedlin@ncoa.org, or Matthew Hubbard at Matthew.Hubbard@ncoa.org.

Sincerely,

Aging Life Care Association
AIDS Drug Assistance Program (ADAP)
AIDs Institute, The
Allergy & Asthma Network
Alliance for Aging Research
Alliance for Patient Access
Alliance for Retired Americans
Allies for Independence
American Association on Health and Disability
American Federation of Labor and Congress of Industrial Organizations (AFL–CIO), The
American Kidney Fund
Arc, The
Assistance Fund, The
Caregiver Action Network
Caring Across Generations
Center for Medicare Advocacy
Colorectal Cancer Alliance
Cooper Neurologic Institute
Depression and Bipolar Support Alliance
Derma Care Access Network
Disability Policy Consortium
Epilepsy Foundation
Families USA
Gaucher Community Alliance
Gerontological Society of America, The
GO2 for Lung Cancer
Headache and Migraine Policy Forum
HealthyWomen
HIV+Hepatitis Policy Institute
International Foundation for Autoimmune & Autoinflammatory Arthritis
International Waldenstrom's Macroglobulinemia Foundation
Justice in Aging
Lakeshore Foundation
LeadingAge
Leukemia & Lymphoma Society, The
Lupus and Allied Diseases Association, Inc.
Lupus Foundation of America
Medicare Rights Center
Melanoma Research Foundation
Mended Hearts, Inc., The

Michael J. Fox Foundation for Parkinson's Research, The
MPN Advocacy and Education International
Multiple Sclerosis Association of America
Muscular Dystrophy Association
National Academy of Elder Law Attorneys
National Adult Day Services Association (NADSA)
National Alliance on Mental Illness
National Association of Councils on Developmental Disabilities
National Association of Medication Access & Patient Advocacy, The
National Association of Social Workers (NASW)
National Committee to Preserve Social Security and Medicare
National Consumer Voice for Quality Long-Term Care
National Council on Aging
National Disability Rights Network (NDRN)
National Eczema Association
National Gaucher Foundation
National Kidney Foundation
National Neutropenia Network
National Organization for Rare Disorders
Patient Access Network (PAN) Foundation
Patients Rising Now
PlusInc
Pulmonary Hypertension Association
RetireSafe
SAGE
Service Employees International Union
Sumaira Foundation, The
TASH
USAgging
Well Spouse Association

cc: Meena Sheshamani
John Blum
Stacy Sanders