towards the chronically ill, meals and transportation, fitness benefits, and the traditional “value-adds” of various forms of dental, vision and/or hearing benefits.

Part D

Data shows an increasing number of Part D beneficiaries exceeding their Part D Catastrophic threshold or True out-of-pocket (TrOOP) limit. Major contributors to this phenomenon are autoimmune therapies, oral oncology drugs, and hepatitis regimens.

Congressional response to this includes proposals from both the House and the Senate, which each provide better member protection in the form of a maximum out-of-pocket (MOOP). Therefore, members will no longer pay 5% in the catastrophic phase. The major proposals additionally eliminate the coverage gap, but neither the House nor the Senate bills entirely absolve the pharmaceutical manufacturers from the percentage share they currently cover in the gap for non low-income subsidy (LIS) members. Instead, with the gap itself eliminated, Pharma will pay a percentage of costs in the Initial Coverage Limit (ICL) and the Catastrophic phases for all (non-LIS and LIS) beneficiaries. Then, they will cover an even higher percentage of costs when beneficiaries are into the Catastrophic Phase. On a nationwide basis, the House and Senate bills generally provide cost reductions to Medicare beneficiaries and shift costs to the pharmaceutical manufacturers. The result is a more neutral impact on the benefit plans themselves. Additional competing variations of the proposals are also under discussion.

A final point on the regulation was that the point-of-sale rebate requirements have been deferred to 2023.

In the final segment, biosimilar drugs are discussed, noting that in the US we have 31 such drugs approved, with 21 of those being launched. They are not considered generics, even though their intent is to mimic the efficacy and use of existing *reference biologic* drugs at a more affordable price. Biologics, and related biosimilars, are all covered under Medicare Part B (rather than Part D).