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March 5, 2018

The Honorable Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
200 Independence Ave, SW  
Washington, DC 20201

Submitted electronically via regulations.gov

Dear Administrator Verma:

AARP is pleased to submit the following comments on the 2019 Medicare Advantage and Part D Advance Notice Part II and Draft Call Letter. AARP, with its nearly 38 million members in all 50 States and the District of Columbia, and US Territories, is a nonpartisan, nonprofit, nationwide organization that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

## ADVANCE NOTICE

**Contract Consolidations and Star Ratings/ Quality Bonus Payments:** CMS is moving forward with its proposed policy in the FY 2019 proposed rule to change how Star Ratings are assigned when MA and Part D contracts operated by the same parent organization and of the same plan type are consolidated. This is a change from CMS' current policy which assigns the surviving contract's Star Ratings to the consolidated contract for the initial period after the consolidation.

The Medicare Payment Advisory Commission (MedPAC) has noted that under the current methodology, consolidations have resulted in beneficiaries being moved from lower-rated to higher-rated contracts, which has increased quality bonus payments to Medicare Advantage Organizations (MAOs). It reports that about 20 percent of MA enrollment have been moved to bonus status over the past five years as a result of 108 consolidations. In particular, MedPAC found consolidation activity was particularly high

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in 2017, with 17 contracts moved to bonus status, affecting 1.7 million or 8 percent of enrollees.

AARP supports steps that would prevent consolidations from masking the performance of the consumed contracts. We therefore support the CMS proposal to assign Star Ratings using an enrollment-weighted mean of the measure scores of the contracts being consolidated. We would also support the alternative proposed by MedPAC under which contract Star Ratings would continue to be reported separately until the contract data being reported reflects the performance of the entire consolidated contract. Moreover, we urge that in addition to applying the proposed enrollment-weighted methodology or the MedPAC alternative to consolidations of contracts under the same parent organization, to the extent practicable, CMS extend the policy treatment to consolidations of contracts between different parent organizations. Finally, AARP supports calculation of Star Ratings at the plan level, not proposed in this Advance Notice but discussed in CMS' proposed rule for 2019.<sup>1</sup> Should CMS adopt this approach in the future, the proposed enrollment-weighted methodology should be extended when consolidations occur under a plan-level Star Rating system. Also, as MedPAC has suggested, Star Ratings would be more useful for comparative purposes if they were calculated for a particular geographic area.

**Treatment of Puerto Rico under Parts C and D Payment, Risk Adjustment and Star Ratings:** On behalf of our members and other older Americans in Puerto Rico, we continue to be extremely concerned about the problems in the healthcare landscape on the island due to the Commonwealth's severe financial distress, a situation which has worsened in the aftermath of Hurricane Maria. As we have communicated to the Department in the past, we have serious concerns about the health and well-being of the island's residents. We thus appreciate CMS' continuing efforts to address potential flaws in the MA payment and Star Ratings methodologies as they may affect payment to MAOs and Part D sponsors operating in Puerto Rico.

CMS notes its continued concerns about the shortcomings of MA payment, MA risk adjustment and the MA and Part D Star Ratings related to plans operating in Puerto Rico. AARP was encouraged that CMS made changes in its 2018 MA and Part D Final Notice to address those shortcomings and we appreciate CMS' continued efforts in this Advance Notice and Draft Call Letter to make additional policy adjustments for 2019 designed to help MA plans in Puerto Rico overcome the disadvantages that they have historically faced. This includes the proposed adjustments in the calculation of its MA plan benchmarks. We also are encouraged by CMS' proposal to continue Star Ratings adjustments for contracts operating solely in Puerto Rico. AARP urges CMS to continue to monitor and assess the status of the MA and Part D plans in Puerto Rico and the effects of these changes in program policy.

**Employer Group Waiver Plans (EGWPs) under Medicare Advantage:** AARP remains very concerned about the potential impact of CMS' proposal to significantly

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<sup>1</sup> CMS, Contract Year 2019 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs Proposed Rule (CMS-4182-P) (82 FR 56336)

change payment policy for EGWPs on retirees. CMS began the transition away from payments to EGWPs on the basis of their bids to payments based on overall county-level individual market bids in 2018 by providing for a 50/50 blend of individual market plan bids and Employer Group Waiver Plan bids from the previous year. In this proposal, CMS now proposes to fully implement the transition for payment to 100 percent individual market plan bids in 2019.

While we support improvements to promote fiscally responsible MA payment policy, we are concerned that CMS proposes to fully implement this proposal at this time without assessing and addressing the direct impact that this change is likely to have on a significant number of retirees enrolled in these plans. CMS estimates this proposal will result in a reduction in EGWP payments by 0.3 percent in 2019.

More than 3.8 million Medicare beneficiaries<sup>2</sup> rely on the health benefits they receive from their former employers through MA EGWPs. This number has increased steadily over the past decade, making EGWPs a significant part of the MA program that now includes nearly 20 million beneficiaries.<sup>3</sup> AARP is concerned that if the proposed CMS policy is finalized, employers may pare back or discontinue their retiree health supplemental benefits, resulting in increased costs for Medicare retirees. Further steps to change the way in which EGWPs are paid should not be taken until the effects of the change on Medicare beneficiaries are fully assessed. If, however, CMS decides to retain the policy as modified by the 2019 Advance Notice, then AARP would support a gradual phase-in of the new policy so as to mitigate its potential impact on affected beneficiaries.

**Updates to the Part D Benefit Parameters:** CMS is required by statute to update the Part D benefit parameters for the standard benefit to reflect the percentage increase in average per capita total Part D drug expenses for Medicare beneficiaries. For the 2019 plan year, CMS specifies that the Part D benefit parameters will increase as follows: the deductible will increase from \$405 to \$415; the initial coverage limit will increase from \$3,750 to \$3,820; and the out-of-pocket threshold will increase from \$5,000 to \$5,100. Total covered Part D spending at the out-of-pocket (catastrophic) threshold will rise from \$8,418 to \$8,907.

AARP remains very concerned about the underlying trends driving the annual Part D benefit parameter updates. The prices of prescription drugs widely used by older Americans are increasing every year, often by double-digit percentages. The average annual cost of one widely used prescription drug reached almost \$13,000 in 2015, or more than half the median income for Medicare beneficiaries over the same time

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<sup>2</sup> [https://www.ahip.org/wp-content/uploads/2017/03/MA\\_EGWPs\\_FINAL\\_324.pdf](https://www.ahip.org/wp-content/uploads/2017/03/MA_EGWPs_FINAL_324.pdf)

<sup>3</sup> CMS, Monthly Contract Summary Report, January 2018, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Contract-and-Enrollment-Summary-Report-Items/Contract-Summary-2018-01.html?DLPage=1&DLEntries=10&DLSort=1&DLSortDir=descending>

period.<sup>4</sup> These trends have serious financial implications for Medicare Part D enrollees, particularly those paying coinsurance, or a percentage of their prescription drug costs, rather than a flat copayment. MedPAC has cautioned that coinsurance amounts on high-priced drugs are likely to discourage some beneficiaries from filling their prescriptions altogether.<sup>5</sup>

MedPAC has also flagged recent prescription drug price trends as a growing concern for the Medicare Part D program as a whole, noting that nearly all of the recent growth in spending for high-cost Part D enrollees is due to higher prices. MedPAC also warned that the use of higher-priced drugs—driven by increased drug manufacturer focus on expensive specialty drugs and biologics—will continue to put strong upward pressure on program spending.<sup>6</sup>

AARP strongly urges CMS to monitor Medicare Part D spending trends and their subsequent impact on enrollees. AARP continues to be concerned about the escalating costs of prescription drugs and the impact those costs have on patients and the Medicare program. We strongly urge CMS to work to identify reforms to lower these escalating costs, and would be happy to work with CMS to identify strategies to do so.

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<sup>4</sup> Stephen W. Schondelmeyer and Leigh Purvis, “Rx Price Watch Report: Trends in Retail Prices of Prescription Drugs Widely Used by Older Americans, 2006 to 2015,” AARP Public Policy Institute, Washington, DC, December 2017.

<sup>5</sup> Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2017, p. 410, [http://medpac.gov/docs/default-source/reports/mar17\\_entirereport.pdf](http://medpac.gov/docs/default-source/reports/mar17_entirereport.pdf)

<sup>6</sup> Rachel Schmidt and Shinobu Suzuki, “The Medicare prescription drug program (Part D): Status report,” MedPAC presentation. January 11, 2018.

## **DRAFT CALL LETTER**

### **Parts C and D**

#### **Enhancements to the 2019 Star Ratings and Future Measurement Concepts**

We appreciate CMS' work to ensure that the Star Ratings system is continually improved and it continues to play a strong role in guiding beneficiaries to find the best plan and ensure that payment policy supports high quality coverage and accountability. We are pleased that CMS intends to consult with a wide variety of stakeholders including consumer representatives.

**Beneficiary Access and Performance Problems (BAPP) (Part C & D):** We are concerned with proposed changes to minimize the results of plan audits and enforcement actions in Star Ratings. In the Advance Notice, CMS proposes to retire the current BAPP measure for 2019 and instead introduce a new measure to only include Compliance Activity Module (CAM) data that would appear only on the display page for the 2019 Star Ratings. The new display measure would not appear to include significant items included in the current BAPP such as CMS' sanctions and civil money penalties (CMP).

We are concerned by this proposal, as we believe such sanctions and penalties are directly tied to a plan's quality. We believe that inclusion of these types of access and performance problems are consistent with beneficiaries' expectations about quality ratings for the MA program and other efforts by CMS to improve transparency around plan sanctions. We are concerned with instances where plan lack of compliance have merited significant sanctions, but their Star Ratings remained high. Therefore, we strongly urge you to reconsider this decision.

Categorical Adjustment Index (CAI). CMS proposes to retain the current methodology for calculating the CAI for 2019. AARP continues to urge CMS to work with stakeholders to review the reports and recommendations of the Assistant Secretary for Planning and Evaluation, the National Quality Forum, measure stewards and others in order to replace the interim CAI with an evidence-based, long-term policy regarding treatment of socioeconomic and disability status on Star Ratings. AARP stands ready to participate in this process. The potential for unintended consequences should be evaluated as part of this review. In particular, AARP is concerned that the CAI or other adjustments may have the effect of masking differences in quality disparities among plans serving vulnerable populations. All plans, including those with a high proportion of low-income and disabled enrollees, should have an ongoing incentive to improve quality performance. CMS should analyze data for potential differences in quality improvement among plans with and without a CAI. Further, CMS should undertake to identify and share best practices from experienced plans that are consistently high performing in serving low-income or Medicare-Medicaid dual eligible enrollees.

Additional Adjustment for Puerto Rico. As noted above, AARP supports the proposal to continue the additional adjustment for contracts with service areas entirely in Puerto Rico. This adjustment reduces the weights for the medication adherence measures to zero for the summary and overall rating calculations in proper recognition of the challenges unique to Puerto Rico, where no LIS applies.

Disaster Implications. AARP supports the proposed adjustment to 2019 and 2020 Star Ratings calculations to take into account the effects of extreme and uncontrollable circumstances that occurred during the performance period such as the disasters that occurred during the 2017 performance period – Hurricanes Harvey, Irma, and Maria, and the California wildfires. In particular, we support recognition of contracts operating solely in Puerto Rico for designation as “affected contracts” without further analysis because of the extreme hurricane damage there and the ongoing disruption in electric power. Additionally, making the Consumer Assessment of Healthcare Providers and Systems survey, the HOS optional for 2018, and reporting of HEDIS measures optional and retaining 2018 Star Ratings (or the higher of 2018 or 2019 when optional measures are reported) for these plans is a reasonable accommodation given the circumstances.

**Plan Finder Civil Money Penalty:** AARP supports CMS’ proposal to display an icon or other type of notice on the Medicare Plan Finder for sponsoring MA or Part D organizations that have received a civil money penalty (CMP). Such penalties are assessed when CMS determines that a CMP is the appropriate enforcement action that should be taken against a sponsor to address identified deficiencies in meeting program requirements. As CMS notes, an icon is currently used to indicate that a plan sponsor is subject to an intermediate sanction. We believe that the proposed addition of an icon in the case of a CMP would be an important step in facilitating better awareness on the part of plan enrollees and prospective enrollees of important differences among the available Part C and Part D plan options. As with other changes to the Plan Finder intended to help consumers in their decision-making, we suggest CMS incorporate consumer testing to ensure that they are designed in a way that helps beneficiaries interpret them appropriately.

**Meaningful Difference (Substantially Duplicative Plan Offerings).** In the *Proposed Rule for the CY 2019 Policy and Technical Changes to MA and Part D*, CMS proposed to eliminate the MA Meaningful Difference test in CY 2019. In this Draft Call Letter, CMS indicates its intent to implement this change in policy as discussed in the proposed rule.

As we commented in our response to the November 2018 Proposed Rule, AARP does not support elimination of the meaningful difference test for Medicare Advantage bid submissions and bid review. We are concerned that if CMS drops the meaningful difference requirement, the number of plan options offered by any one Medicare Advantage organization in an area will proliferate, without providing any significant improvement in the array of choices offered to beneficiaries. Instead, the increased number of options is likely to make it even more difficult for beneficiaries and those who help them navigate the Medicare Advantage program to choose among the different plan options. Given the complexity of sorting through differences in premiums, cost-

sharing features, plan provider networks and more, even those beneficiaries who are the most insurance literate face challenges today in making plan selections. While various tools are available to assist beneficiaries, and improvements have been made to the Medicare Plan Finder, such tools are not alone sufficient to help consumers discern meaningful differences between plan choices, and thus the meaningful difference test is necessary. While we appreciate that CMS plans to retain other provisions of current regulations that help to safeguard beneficiaries from discriminatory benefit design, we remain concerned that eliminating the meaningful difference test may encourage plan risk segmentation based on benefit design.

**Total Beneficiary Cost (TBC):** CMS currently applies a “total beneficiary cost” test to determine if an MA organization’s proposed bid should be denied because the bid includes too significant an increase in cost sharing or a decrease in benefits from one year to the next. This test helps protect MA plan enrollees who continue in the same plan from one year to the next from experiencing significant cost increases. For 2019, CMS proposes to increase the current TBC threshold from \$34 per member per month to \$36 per member per, explaining that the increase is needed to provide flexibility to MA organizations in addressing medical and pharmacy inflation and making benefit design and formulary changes. CMS also notes that it included in its Proposed Rule an elimination of the TBC evaluation in future years.

AARP opposes elimination of the TBC evaluation. We believe it provides a useful metric by which to discourage significant enrollee cost-sharing by a Medicare Advantage plan from one year to the next. If plans are not reviewed for annual changes in their total beneficiary costs, we fear that they would be more likely to make annual cost-sharing changes that could have subtle effects on plan selection and that some beneficiaries may not appreciate significant changes that may result in significant increases in their out-of-pocket liabilities.

AARP remains disappointed that CMS has chosen not to adopt a policy of denying Part D plan bids with significant increases, as measured by the TBC metric. As CMS noted in its February 2016 Advance Notice and Call Letter, this authority is provided to CMS under Section 3209 of the Affordable Care Act. We strongly urge CMS to reconsider this decision, as a TBC measure could help protect enrollees from unexpected increases in cost sharing, particularly given their tendency to remain in the same plan from one year to the next.

**Part C Cost Sharing Standards:** AARP strongly supports CMS’ current policies designed to encourage MA organizations to limit the maximum out-of-pocket costs an enrollee can experience in a plan year for in-network Parts A and B services. CMS currently does this by granting MA plans greater flexibility in establishing their Parts A and B cost sharing if they adopt lower, voluntary maximum out-of-pocket limits than are available to plans that adopt the higher mandatory maximum amounts. CMS also monitors the cost sharing for specific services, such as cardiac and pulmonary rehabilitative services, to ensure that plans are not imposing higher-than-specified limits. This helps to safeguard MA plan enrollees with potentially high-cost conditions

from inappropriately high and potentially discriminatory cost-sharing amounts. For this reason, we oppose any step away from the existing standards.

**Tiered Cost Sharing of Medical Benefits:** AARP remains concerned with the potential for significant beneficiary confusion about their benefit options and resulting cost sharing responsibilities that arises with tiered cost sharing. AARP urges CMS to develop safeguards for beneficiaries with respect to the use of tiered cost sharing and closely monitor marketing and implementation by plans. CMS should work closely with MAOs to monitor marketing information and ensure that beneficiaries understand tiered cost sharing and the consequences for them. This type of transparency should be readily accessible on the Plan Finder so that prospective as well as current enrollees are able to determine whether such tiered cost sharing is used by a specific MA plan.

**Health Related Supplemental Benefits:** CMS proposes to allow MAOs greater flexibility to offer health related benefits as “supplemental benefits”. The proposed change would allow supplemental benefits that “compensate for physical impairments, act to ameliorate the functional/ psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization.”

In general, we believe allowing for greater coverage of these types of benefits, whether under MA or under traditional Medicare, can be a positive improvement for beneficiaries. AARP has been supportive of efforts to expand coverage for benefits beyond those that prevent, cure, or diminish an illness or injury, particularly for beneficiaries with multiple chronic conditions, as they can be important to better addressing the needs of many Medicare beneficiaries. For example, we support the recently enacted provision of H.R.1892, the Bipartisan Budget Act of 2018, to target benefits for chronically ill enrollees. Under that provision, beginning in 2020, a Medicare Advantage plan will be able to provide supplemental benefits that, with respect to a chronically ill enrollee, have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee and may not be limited to being primarily health related benefits.

However, we urge CMS to ensure that this proposal is implemented appropriately. Careful oversight and rules should be implemented to ensure that such health related supplemental benefits are made available to enrollees in a fair and appropriate manner, and coverage decisions are made in a fair and transparent manner. In addition, CMS should ensure that these benefits are not marketed in an inappropriate manner, does not mislead beneficiaries or lead to risk segmentation. We are concerned that CMS’ proposal does not contain such safeguards and plans for appropriate oversight. We urge CMS to include plans for such careful oversight in future guidance for MAOs. CMS should also appropriately consider these points in implementing the provision noted above in H.R. 1892.

**Medicare Advantage Uniformity Flexibility:** As AARP commented in response to CMS’ MA and Part D November 2018 Proposed Rule, we have concerns about CMS’ proposal to relax the requirement that Medicare Advantage plans offer all enrollees



access to the same benefits at the same level of cost sharing, beginning in 2019. We are generally supportive of the broad idea of allowing MAOs to offer tailored supplemental benefits and reduced cost-sharing to better meet the needs of beneficiaries' health conditions, including those with chronic conditions. For example, we have supported CMMI's VBID demo, and we supported provisions in H.R. 1892, the Bipartisan Budget Act of 2018 which includes a provision to target MA benefits to a carefully defined set of chronically ill enrollees. However, we have concerns with implementation of this specific proposal. In addition, as discussed below, CMS proposes revising its policy to exercise uniformity flexibility within each segment of an MA plan.

While we are pleased that Congress included in that provision a requirement that the Secretary allocate funds to evaluate the VBID demonstration, we believe that type of evaluation should occur prior to CMS changing its approach to the uniform benefit requirement.

Regardless of how CMS proceeds with benefit flexibility and exceptions to the uniformity requirement, CMS should continue to monitor potential discrimination if a plan is targeting cost-sharing reductions and additional supplemental benefits for specific disease conditions while excluding other higher-cost conditions. If the scope of the new CMS policy under the Draft Call Letter is too broad, the new benefit and cost-sharing flexibilities will give rise to increased complexity of benefit design, reduce the transparency required to ensure clear and understandable benefit and cost-sharing features of each plan and increase the potential for risk segmentation based on plan benefit design. We are also very concerned about CMS' capacity to adequately provide oversight to prevent potential discrimination, which will become a significantly more challenging task under the proposed changes.

**Segmented Benefits Flexibility:** AARP's concerns described above about CMS' proposed changes related to plan flexibility in benefit and cost sharing extend to its proposed change to allow plan segments (county-level portions of a plan's service area) to vary by benefits in addition to varying by premium and cost sharing. CMS' proposed interpretation contrasts with the current policy prohibiting such segment variation. We view this proposed change as contributing to more rather than less program complexity and we worry about the capacity of CMS to carefully scrutinize the compliance of any one MA organization's plan variations when many more variations are likely to arise as a result of this proposed change. We strongly urge CMS to more carefully evaluate the potential impact this change could have on promoting regional disparities, which we believe could be a significant concern.

**SNP Network Adequacy:** We support CMS' efforts to conduct ongoing evaluations of the network adequacy of SNPs. We also urge CMS to publicly disclose its findings from the evaluations.

**Transparency and Timeliness with Prior Authorization (PA) Processes:** CMS acknowledges stakeholder concerns about the burdens on beneficiaries imposed by

coverage restrictions such as prior authorizations (PA) in the Part C program. We greatly appreciate CMS' explicit reminder to MAOs that they should be transparent and provide adequate notice of any coverage restrictions, such as PA requirements, to both providers and enrollees. This is an arena where transparency and notice are absolutely critical to the ability of enrollees to obtain needed services on a timely basis.

## **Part D**

**Part D Over-the-Counter (OTC) Enhancements:** CMS is contemplating allowing additional flexibilities for Part D plan sponsors to broaden access to over-the-counter drug products (OTCs). For example, CMS could consider allowing sponsors to include additional OTC products such as dietary supplements and cough medicines, without the requirement that the OTC product offset the use of a Part D drug. CMS notes that such a policy change could potentially increase program costs and that the beneficiary inducement laws still apply.

While AARP appreciates the idea behind this proposal, we believe that it may be premature in light of recent efforts to reform FDA's processes for regulating OTC medicines. The current regulatory system is outdated and makes it difficult to update product labels with new safety information or approve new ingredients. In combination with limited funding, this system has reduced FDA's ability to protect consumer health.<sup>7</sup> Consequently, AARP believes that any efforts to expand Part D coverage of OTC products should wait until these challenges are resolved.

Further, CMS previously noted that, while the potential cost savings associated with using certain OTCs is significant, it does not believe that many OTC products will offer such savings.<sup>8</sup> As such, we would be hesitant to support expanding Part D coverage of OTC products in the absence of clear and compelling evidence that it would reduce both beneficiary and program costs.

Finally, AARP strongly urges CMS not to expand Part D coverage to include dietary supplements. We are aware that many consumers use such products; however, we are extremely concerned by the lack of assurance that dietary supplements are of high quality and safe for use. The Government Accountability Office has repeatedly criticized the regulation of dietary supplements and called for additional FDA authority to oversee supplements and improve consumer understanding of their safety, efficacy, and labeling. Given these considerable safety concerns, we do not believe that Part D plans should extend coverage to such products.

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<sup>7</sup> Janet Woodcock, Testimony before the Subcommittee on Health, House Energy and Commerce Committee, U.S. House of Representatives, September 13, 2017.

<sup>8</sup> CMS, "Can Part D plans include OTCs as part of administrative expenses since they may provide significant cost savings as part of a utilization management program?" Available online: [https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/QACY2007OTCsandUM\\_051206.pdf](https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/QACY2007OTCsandUM_051206.pdf)

**Part D Benefit Parameters for Non-Defined Standard Plans:** As we commented in response to CMS' November 28, 2017 MA and Part D Proposed Rule, AARP opposes the elimination of the requirement that Part D plan sponsors demonstrate meaningful differences among their Prescription Drug Plan Enhanced Alternative offerings. Beneficiaries are already being asked to navigate a wide array of plan choices, a task that has proven challenging for even the most educated beneficiaries. We believe that this change will make it even more difficult for Medicare beneficiaries to distinguish between the plan options in their area, particularly given CMS' estimates that as many as 125 additional enhanced plans (a 15 percent increase) could be offered due to the proposed change. Although we appreciate CMS' interest in encouraging greater competition and innovative plan designs, we believe that the proposed elimination of the meaningful differences standard for Enhanced Alternative plans is misguided.

Given our concerns about the need for clear distinctions among prescription drug plan options, we are reassured that CMS has decided to maintain its requirement that plan sponsors demonstrate meaningful differences between their basic and enhanced prescription drug plan offerings. AARP would strongly oppose the elimination of the meaningful difference requirement in this regard.

**Benefit Review:** AARP supports CMS's continued scrutiny of the expected cost-sharing amounts incurred by beneficiaries under Part D plan coinsurance tiers in order to more consistently compare the effects of copay and coinsurance cost-sharing amounts, including whether plan cost-sharing is discriminatory. We also are pleased that CMS intends to evaluate the drug composition of copay tiers to assess whether the formulary and benefit structure is providing a meaningful benefit. We believe that these are important elements in CMS' oversight of Part D plans and help to ensure that plan options meet program standards.

**Tier Composition:** CMS notes that it will continue to evaluate the brand/generic composition of the non-preferred brand tier as part of the bid review process and proposes a policy of a maximum threshold of 25% generic composition for a non-preferred brand tier for CY 2019. AARP supports this distinction and agrees that the inclusion of a significant number of generic drugs on a tier that is labeled as brand could lead to enrollee confusion.

AARP strongly urges CMS to continue to monitor the tier composition shifts that are taking place within Part D plans and ensure that tier labels are as accurate as possible. AARP further urges CMS to ensure that cost-sharing for "mixed" tiers does not result in Part D enrollees paying the full cost of less expensive covered drugs or paying prohibitively high cost-sharing for expensive covered drugs.

**Specialty Tier:** CMS proposes to retain the current specialty tier threshold of \$670, which was raised in 2017 and the first increase in 8 years. AARP continues to be concerned that this threshold amount is not high enough. The prices of specialty drugs

widely used by older Americans are increasing by double-digit percentages every year<sup>9</sup> and more and more high-priced specialty drugs are entering the market. A low specialty tier threshold could allow plans to place a growing number of drugs—or even all of the drugs available in a given therapeutic class—on its specialty tier. Further, as MedPAC has cautioned, coinsurance amounts on high-priced drugs such as those in the specialty tier are likely to discourage some beneficiaries without the Part D low-income subsidy from filling their prescriptions altogether.<sup>10</sup> Consequently, we urge CMS to reevaluate the specialty tier threshold amount and to make increases consistent with recent prescription drug price trends.

**Low-Enrollment Plans (Stand-alone Prescription Drug Plans (PDP) only):** AARP supports CMS' proposed policy to exercise its authority not to renew a stand-alone PDP if it meets its criteria for a low-enrollment plan for two consecutive years. We believe that CMS' criteria provide for a reasonable test of whether a PDP is likely to continue to be viable and able to provide Part D services. However, we urge CMS to proceed with caution if a situation arises where a low-enrollment PDP is one of the few PDP options in an area or is the only one that is priced at or below the low-income benchmark premium amount. Above all else, CMS must ensure the continuation of adequate access to affordable stand-alone prescription drug plans. If CMS decides to renew a low-enrollment plan in order to ensure sufficient plan options, CMS should intensify its oversight of that plan.

### **Improving Drug Utilization Review Controls in Medicare Part D**

CMS proposes several changes that would strengthen the monitoring of opioid use among Medicare beneficiaries and provide new tools to plans to reduce the unsafe use of opioids. The changes include additional monitoring under the CMS Overutilization Monitoring System (OMS) and new claims edits that would be applied during concurrent drug utilization review at point of sale (POS).

AARP supports CMS' continued efforts to provide tools to plans to reduce opioid abuse including the identification of high-risk use through the OMS monitoring system.

However, AARP remains concerned that efforts to detect and prevent overutilization may inadvertently result in beneficiaries being unable to obtain medically necessary medications. Therefore, we urge CMS to provide for rigorous monitoring to ensure that plans do not impede legitimate access to these prescribed drugs. CMS should also ensure that its systems for applying hard and soft POS edits do not become so complex that providers begin to ignore or disregard cases because the number of POS edits is

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<sup>9</sup> Stephen W. Schondelmeyer and Leigh Purvis, "Rx Price Watch Report: Trends in Retail Prices of Specialty Prescription Drugs Widely Used by Older Americans, 2006 to 2015," AARP Public Policy Institute, Washington, DC, September 2017.

<sup>10</sup> Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2017, p. 410, [http://medpac.gov/docs/default-source/reports/mar17\\_entirereport.pdf](http://medpac.gov/docs/default-source/reports/mar17_entirereport.pdf)

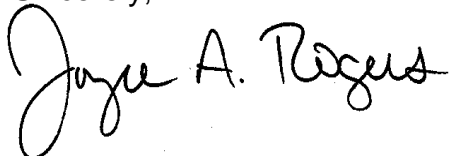
overwhelming. Similarly, CMS processes should not become so burdensome that they have the inadvertent result of pushing individuals to seek pain relief via illegal means.

AARP further urges CMS to consider providing prescribers with feedback about over- (and under-) utilization. Prescriber-level interventions such as continuing education on controlled substances should be addressed more globally, not just through plan-sponsored point-of-sale interventions.

**Mail Order Refill Consent Policy:** AARP appreciates the opportunity to respond to CMS's request for comment on whether CMS should revise its policy requiring Part D sponsors of non-EGWP plans to obtain consent from beneficiaries prior to shipping refills of mail-order prescriptions. We believe it is possible to develop auto-ship refill programs that balance the goals of improved medication adherence and convenience with preventing waste and thus urge CMS to move forward with developing proposed guidelines or principles for an opt-out consent approach. Such an approach should include appropriate safeguards to ensure that beneficiary participation in auto-ship refill programs is voluntary and that users always have the opportunity to stop unwanted or unneeded prescriptions. It will also be important to include in the revised auto ship policy a requirement that the plan provide for full refunds for any refills that are auto shipped that a beneficiary reports or returns as unneeded or otherwise unwanted.

Thank you for the opportunity to comment on these important issues. If you have any questions, please do not hesitate to contact Brendan Rose on our Government Affairs staff at 202-434-3770 or [brose@aarp.org](mailto:brose@aarp.org).

Sincerely,

A handwritten signature in black ink that reads "Joyce A. Rogers". The signature is fluid and cursive, with the first name "Joyce" being the most prominent part.

Joyce Rogers  
Senior Vice President, Government Affairs