



**National Patient
Advocate Foundation**

January 16, 2018

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Re: Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program

Dear Administrator Verma,

National Patient Advocate Foundation (NPAF) is pleased to provide feedback to the Center for Medicare and Medicaid Services (CMS) proposed rule (CMS-4182-P) regarding changes to Part D and Medicare Advantage beginning contract year 2019. NPAF represents the voices of millions of adults, children and families coping with chronic and serious illnesses nationwide as the advocacy affiliate of Patient Advocate Foundation (PAF). PAF provides direct assistance and support services to improve people's quality of life by reducing financial burdens and overcoming other obstacles to care. Experiences from PAF case managers assisting thousands of low-income patients each year fuels our person-centered and family-focused agenda.

NPAF applauds CMS for seeking formal feedback regarding a new policy for passing through manufacturer rebates to patients and supports the proposal that all pharmacy price concessions be applied at the point of sale. NPAF supports CMS in efforts to reform Medicare Part D to ensure medications for patients and families are affordable. In 2016, Medicare beneficiaries accounted for 68% of all PAF patients receiving copay assistance for prescription drugs.¹ Overall, proposals regarding Medicare Advantage appear to align with patients' best interests, however, CMS should further assess whether patient protections are at risk because of greater Medicare Advantage plan flexibility and autonomy.

As CMS notes in the proposed rule, Medicare Part D plan sponsors or their pharmacy benefit managers (PBMs) independently negotiate rebate amounts and price concessions between manufacturers and pharmacies, which could be uniformly applied to lower all beneficiary premiums and/or applied individually to lower the cost-sharing responsibility for patients' medications at the pharmacy counter. However, because arrangements are confidential, it is difficult to determine whether or to what extent Part D plan sponsors are passing through savings at the point of sale. We

¹ Patient Advocate Foundation. Demographics of PAF Co-Pay Relief Patients by Payer in 2016.

share CMS' concern that since patients' cost-sharing amount is typically based on the list price of a drug, rather than the lower negotiated price which accounts for rebates and price concessions, Medicare beneficiaries may be overpaying for medications in the Part D program.

We support and appreciate CMS efforts to improve transparency and protect patients from paying a larger share of the drug costs, which occurs when rebates and price concessions are not reflected in negotiated price at the point of sale. Patients and families are far removed from these arrangements but should regardless share a portion of the savings that balance lower premiums and cost-sharing. A recent analysis of drug rebates on patient and Medicare spending suggests that reconfiguring cost-sharing by utilizing copayments rather than coinsurance, for certain high-cost specialty drugs, could lower out-of-pocket costs for patients.² CMS should explore options that balance monthly premiums with cost-sharing at the point of sale, ensuring information on savings offered by plans is shared in an easily understandable format, as both constitute important financial information that patients and families need to make important healthcare decisions such as plan enrollment or treatment selection with their physician. As such, CMS could enhance usability and simplify the Medicare Plan Finder tool to better assist patients and families with decision-making, involving their perspectives about what is helpful in the process.

CMS should consider trends in commercial plan practices that could potentially be mirrored by private Part D sponsors. Survey data indicates that in 2017, only 4% of employer-based commercial plans used manufacturer rebates to lower patient's out-of-pocket costs, 11% used rebates to offset member premiums, but the great majority (68%) used rebates to lower plan spending on drugs.³ CMS' proposal to establish a minimum percentage of manufacturer rebates that must be applied at the point of sale would help ensure rebates are equitably and consistently passed down regardless of which plan a patient selects. CMS could also require and obtain more complete data about contractual arrangements between manufacturers and payers or PBMs that includes rebates at the individual drug level. As CMS seeks to effectively design policies that require Part D sponsors to pass through savings to patients, this data can be used to identify and test innovative benefit design models that work best for Medicare beneficiaries and ensure that patients and families confronting serious, chronic illness have equitable access to often life-saving medications.

Finally, NPAF urges CMS to identify and address any unintended consequences of several proposed changes to Medicare Advantage plans such as eliminating meaningful difference requirements and scaling back CMS oversight for certain marketing materials including grievance and appeals processes. Specifically, CMS notes intent to update the Medicare Plan Finder tool to improve beneficiary experience, however, eliminating meaningful difference requirements between plans may make it more difficult for patients to determine which plan is best for their unique circumstances. CMS should prioritize implementing a more robust search and compare function in

2 Dusetzina SB, Conti RM, Yu NL, Bach PB. Association of Prescription Drug Price Rebates in Medicare Part D With Patient Out-of-Pocket and Federal Spending. *JAMA Intern Med.* 2017 August 01; 177(8): 1185–1188

3 Pharmacy Benefit Management Institute. 2017 Trends in Drug Benefit Design. Retrieved Jan 8, 2018. Available at: https://www.pbmi.com/PBMI/Research/PBMI_Reports/Drug_Benefit_Reports/PBMI/Research/Store/BDR.aspx?hkey=bfcca9f8-610e-4eca-a908-8ff451bb2f87

the Medicare Plan Finder tool, that highlights meaningful advantages and disadvantages, personalized to each beneficiary. Additionally, NPAF is concerned that reduced oversight and narrowing the definition of “marketing materials” may lead to increased confusion and unnecessary stress on patients and families. NPAF disagrees with CMS’ determination that grievance and appeals process materials are outside the scope of marketing oversight. Importantly, grievance and appeals processes should remain standardized to ensure that patients can equitably file a complaint or request a coverage redetermination if a medication or service was denied. We suggest that CMS reconsider oversight of these marketing materials to protect patients from receiving inadequate or confusing information that limits their ability to efficiently file a grievance or begin an appeal request.

NPAF is encouraged by the proposed rule’s positive steps towards ensuring price transparency for important medications that patients and families need and creating a better healthcare experience for Medicare beneficiaries. We also urge CMS to reconsider various proposals that could negatively impact patient and family experiences in Medicare Advantage. NPAF stands ready to offer person-centered insights to the various improvement initiatives to ensure that all patients are protected from financial burden and that their interests are balanced with health plan flexibility. Please contact Nicole Braccio, policy director, at Nicole.Braccio@npaf.org if NPAF can provide further details or assistance.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "Rebecca A. Kirch".

Rebecca A. Kirch, JD
Executive Vice President, Health Care Quality and Value
National Patient Advocate Foundation