January 16, 2018

Seema Verma

Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-4182-P

P.O. Box 8013

Baltimore, MD 21244-8016

Submitted electronically to [www.regulations.gov](http://www.regulations.gov)

Re: CMS-4182-P

To Whom It May Concern:

The National Council on Aging (NCOA) appreciates the opportunity to comment on the proposed changes to the Medicare Advantage, Medicare Fee-for-Service, and the Medicare Prescription Drug Benefit programs (CMS-4182-P). The National Council on Aging (NCOA) is one of the nation’s leading nonprofit service and advocacy organizations representing older adults and the community organizations that serve them. Our goal is to improve the health and economic security of 10 million older adults by 2020.

Our comments focus on the impact of the proposed regulatory changes on Medicare beneficiaries. We recognize the importance of other stakeholders and the need for Medicare to be an efficient and flexible program. However, given that Medicare is the primary health insurance for over 55 million Americans and 10,000 people age into Medicare every day, CMS must give heavy consideration to the impact of any proposed changes on beneficiaries and ensure that access to and affordability of health and drug benefits remains a key tenet of the Medicare program.

Implementation of the Comprehensive Addiction and Recovery Act of 2016 (CARA)

As part of the proposed framework under which Part D plan sponsors may establish a drug management program for at-risk beneficiaries, CMS is proposing that at-risk beneficiaries (or an at-risk beneficiary's prescriber, on behalf of the at-risk beneficiary) must affirmatively request IRE review of adverse plan level appeal decisions made under a plan sponsor's drug management program. An adverse redetermination would not be automatically escalated to the Part D IRE, unless the plan sponsor fails to meet the redetermination adjudication timeframe.

NCOA does not agree with the CMS’s interpretation of the CARA language on appealing a lock-in determination. Auto escalation would ensure beneficiary due process and access to needed prescription drugs. While the Part D appeals process does not include the auto-escalation of benefit denials to the IRE, the lack of auto-escalation is a significant barrier to the entire Part D appeals process, burdening the Part D enrollees with red tape and hindering their access to Part D drugs.

CARA[[1]](#footnote-1) requires the initial beneficiary notice of lock-in to include information on “the option of an automatic escalation to external review.” As explained further in the same statutory provision, this is “(similar to the processes established under the Medicare Advantage program under part C of title XVIII of the Social Security Act that allow an automatic escalation to external review of claims submitted under such part).” CMS has instead proposed to provide “the right to a reconsideration or expedited reconsideration” to the IRE. Expedited appeals provide for shorter time frames for consideration and action on an appeal of a plan decision. It is very different than auto escalation that provides for an automatic independent review of a plan’s negative decision on a beneficiary’s appeal of a lock-in.

Additionally, the lack of auto-escalation increases the timeframe for the lock-in appeals process. CMS has proposed to add case-management and physician agreement when a beneficiary is at risk for prescription drug abuse. While NCOA applauds these patient protections, they create additional hurdles and delays for beneficiaries who are not at-risk and do need the “frequently abused drugs”. Auto-escalation to the IRE would ensure that there are no further delays in considering the appeals of the locked-in status.

Furthermore, plans have a poor record of complying with current requirements for timely appeals**.** CMS audits[[2]](#footnote-2) of Part C and Part D plan sponsors found that, after not having disposed of the appeal in the required time at the plan level, the sponsors do not auto-forwarded to the IRE as required in the required timeframe either. This “non-compliant condition” is described as “Sponsor did not appropriately auto-forward coverage determinations and/or redeterminations (standard and/or expedited) to the Independent Review Entity (IRE) for review and disposition within the CMS required timeframe.” This non-compliant condition has been present in 5 of the 7 years CMS has conducted the audits. Of the plans audited in 2015 and 2016, 22 plans of 54 (or 41%) were found to be out of compliance with this basic beneficiary protection. As some plan sponsors are not considering redeterminations in a timely fashion and not currently auto-forwarding the appeals they do not complete according to CMS timelines, the lack of auto-escalation delays the appeals process further, thus infringing on beneficiary’s right to due process.

A lock-in is a significant curbing of a beneficiary’s rights to choose their pharmacy and their physician and requires nothing less than an automatic reconsideration by the IRE when the plan has denied a beneficiary’s appeal of their locked-in status. We urge CMS to implement the law as written and auto-escalate a locked-in beneficiary’s appeal of a plan’s negative decision to lock them into a single provider and/or pharmacy.

Flexibility in the Medicare Advantage Uniformity Requirements

NCOA has concerns with the proposal to increase flexibility in the Medicare Advantage Uniformity requirements. Loosening uniformity requirements in the manner CMS proposes could – by itself -- create a chaotic environment for Medicare beneficiaries trying to make informed decisions about what options might be best for themselves. Should CMS choose to proceed with increasing flexibility in these requirements, it must, at a minimum, include basic consumer protections and oversight included in the value-based insurance design (VBID) demonstration, which began in January 2017. When CMMI first proposed a VBID demonstration, beneficiary advocates provided extensive feedback. The resulting demonstration model reflects careful consideration of many important beneficiary protections. Such protections, or guard rails, included strong and clear parameters for program design, including: a multi-stakeholder and transparent process for identifying high-value services and developing conditions of participation; permitting only cost-sharing reductions; limiting or prohibiting advertising and other pre-enrollment marketing of cost sharing adjustments; and opt-in beneficiary selection.

CMS’ must establish similar important beneficiary protections if it proceeds with this proposal, including:

* conditions of participation for plans – plans under sanction and plans with below-average star rating should not be permitted increased flexibility;
* utilization of only positive reinforcement in the form of lowered cost-sharing and expanded benefits, rather than discouragement of lower-value services (in other words, “carrots” v. “sticks”);
* limit approval of lower cost-sharing only to instances where there is a well-established evidence-base that illustrates a particular service, prescription medication, or health care provider is in fact “high-value.” We also encourage CMS to develop a standardized list of health care services or prescription drugs that may be subject to altered cost-sharing in consultation with clinicians and other experts;
* evaluation and monitoring: enrollee protections, like marketing prohibitions, are ineffective and without force unless compliance is monitored and enforced.
* establish a clear strategy and requirements for health care provider and beneficiary education and outreach.
* Transparent evaluation and outcomes: We urge CMS to publish annual reports highlighting how the increase in flexibility affects beneficiaries, if CMS proceeds with this proposal.

Meaningful Differences in Medicare Advantage Bid Submissions

NCOA is concerned by CMS’ proposal to eliminate the meaningful differences requirement for Medicare Advantage (MA) plans. As the rule states, this change would substantially increase beneficiary confusion. Beneficiaries already face complex choices when shopping for an MA plan – on average, beneficiaries have a choice of 21 MA plans. In 206 counties, beneficiaries chose from among more than 30 plans for the 2018 plan year.[[3]](#footnote-3) CMS suggests this proposal is acceptable because beneficiaries understand the basics of health insurance. Research shows this is not the case; in fact, beneficiaries are more likely to enroll in plans when presented with fewer choices. In multiple studies, beneficiaries had higher rates of enrollment in Medicare Advantage plans when presented with 15 or fewer plans. Empirically, more choice may be detrimental if there are too many or overly complex options, particularly in high-stakes decisions that involve health or money. Beneficiaries may choose inferior options or make no choice at all as a result of cognitive overload, anticipated regret, or bias toward the status quo.[[4]](#footnote-4),[[5]](#footnote-5) Consumer testing in Massachusetts also suggested that consumers prefer less variation. This state enacted reforms that used actuarial value tiers that are similar to those in the Affordable Care Act. Focus group testing found that 6-9 distinct plan designs were the ideal number.[[6]](#footnote-6)

Although a great deal of information is available, beneficiaries often have difficulty understanding its significance and using it correctly to make decisions. In focus group testing, it became clear that beneficiaries can’t assess the “value” of health plans, become confused by cost-sharing terms, and overall dread the experience of shopping for health insurance.[[7]](#footnote-7) Most beneficiaries have difficulty correctly interpreting even simple displays of Medicare health plan information.[[8]](#footnote-8)

Additionally, NCOA recently conducted a series of in-person beneficiary interviews in which beneficiaries shopped for a plan on Plan Finder, and provided feedback for a report on Medicare Plan Finder, to be released in 2018. The beneficiaries interviewed were visitors at four different senior centers, and chosen to ensure a diverse sample based on factors such as age, education, and race. Most beneficiaries interviewed showed little or no health literacy. For example, many beneficiaries superficially understood that copays, coinsurance, and deductible represent out-of-pocket costs, but could not indicate any more about how these types of cost-sharing differed from each other. Thus, beneficiaries were unable to compare plans successfully that had differences in these factors.

CMS suggests that this proposal would allow organizations to develop Medicare Advantage plans with tiered and narrow provider networks. This would be particularly concerning for beneficiaries, given that current tools for consumers make it difficult to identify which providers are in network. The current version of Plan Finder lacks an integrated provider directory for Medicare Advantage plans. During interviews, beneficiaries expressed frustration with the need to exit the Plan Finder website to search for providers on individual plan websites. Multiple beneficiaries suggested that they found this process complex – both because of the need to switch between websites, and because of the lack of standardization between provider directories for different plans. Many of the beneficiaries suggested they would have gotten too frustrated to complete the task without human assistance.

Before CMS even considers repealing the meaningful differences requirement, it is crucial to prioritize comprehensive updates to beneficiary tools, such as Medicare Plan Finder. In addition to highlighting the inadequacies of the provider directories, beneficiaries interviewed by NCOA also expressed frustration about other parts of the website, including layout, display, the lack of personalized costs, and the inability to use the website to compare Medicare Advantage with the option of Original Medicare and Medigap.

At the same time, improvements to the ANOC are long overdue. We continue to advocate for an individualized MA and Part D ANOC to better serve individual beneficiary needs, specifically one that details which specific providers are leaving a plan network, which specific prescription drugs are no longer on the plan formulary, and where utilization management tools will be newly applied. Ideally, these customizations should reflect an individual’s actual providers, services, and prescription drugs.

We strongly urge CMS to consider opportunities to tailor these notices to individual information needs. At a minimum, we suggest that CMS solicit input from multiple stakeholders on recommendations to improve the ANOC, EOC, and other standardized materials used during the annual election period. CMS’ commitment to stakeholder input through the comment process for the Welcome to Medicare packet in 2017 was an example of a potential process for modernizing other Medicare notices. It is important to improve all beneficiary decision aids, including mailings and 1-800-MEDICARE, so beneficiaries can more easily use them to understand their choices when shopping for Medicare plans.

At a minimum, instead of completely repealing the meaningful differences requirement, CMS should propose an alternative test of meaningful differences that may address concerns from plans. For example, CMS could work with stakeholders to develop a test that incorporates differences in benefit structure. CMS could also allow plans to seek waivers by providing alternate evidence of meaningful differences. For example, CMS could require that if the current meaningful difference standard were not met, plan sponsors would have to provide stronger evidence that beneficiaries would be able to easily distinguish between the sponsor’s offerings. Applying the meaningful difference standard as leverage would provide CMS with tools to address any confusion.

Coordination of Enrollment and Disenrollment through MA Organizations

We appreciate CMS’ effort to limit the practice of seamless conversion of beneficiaries. As we have noted previously, we believe CMS should advance policies that encourage people new to Medicare to make an active and informed choice about the coverage option(s) that are right for them, selecting among Original Medicare, Medicare Advantage plans (including integrated Medicare-Medicaid options), supplemental Medigap policies, and stand-alone Part D prescription drug plans. CMS noted an intention to establish a “simplified election process” for beneficiaries who are not dually eligible, but want to convert their commercial coverage to a Medicare Advantage plan with the same parent organization. We strongly urge CMS to ensure that such an election process relies on clear notice and positive affirmation from beneficiaries. We look forward to seeing further guidance on this process.

For individuals in Medicaid managed care plans, the start of Medicare eligibility can lead to more fragmented care, because their coverage of Part A and B services and Part D drugs may now be provided separately, either through FFS Medicare or through MA plans or Part D plans offered by other organizations. In these instances, automatic enrollment into an affiliated D– SNP plan can promote the use of integrated care (e.g., shared provider networks) by encouraging these beneficiaries to receive both their Medicare- and Medicaid-covered services from the same organization. We therefore support CMS’s proposal to resume the use of seamless conversion for dual eligible in the limited circumstances provided in this proposed rule.

Part D Tiering Exceptions

NCOA appreciates CMS’ commitment to clarifying the tiering exceptions process, and thus finding solutions to provide lower cost-sharing for beneficiaries taking expensive therapies. NCOA encourages CMS to explore other solutions to reduce the out-of-pocket burden facing these beneficiaries utilizing specialty tier drugs, including: 1) performing more stringent discrimination review to ensure that certain classes of drugs are not always placed on specialty tiers; and 2) allowing cost sharing exceptions for specialty tier drugs.

We encourage CMS to provide more education to beneficiaries regarding options for tiering exceptions. Very little information exists for beneficiaries, and what information beneficiaries have is difficult to understand and apply to individual situations. Forms of education should include beneficiary notices, in particular at the pharmacy. Additionally, CMS should provide clearer information through 1-800-MEDICARE about the tiering exceptions process and how beneficiaries may engage in it if necessary. In addition to education from CMS, plans and pharmacies should have responsibility for educating beneficiaries on the tiering exceptions process. There is currently no oversight of the plans or pharmacies’ role in tiering exceptions, and they must be accountable for informing beneficiaries.

Establishing Limitations for the Part D Special Election Period (SEP) for Dually Eligible Beneficiaries

While the SEP is not widely used by dually eligible beneficiaries currently, it provides an important avenue to access for dually eligible and LIS beneficiaries. In particular, beneficiaries may increase their reliance on SEPs as a result of the proposed policy to allow expedited midyear formulary changes. Limiting the SEP to once a year poses greater risk for beneficiaries while fixing a problem that does not exist, as CMS states itself. At a minimum, we strongly urge CMS to expand a proposed limit to 2 or 3 SEPs during a plan year.

Medicare Advantage and Part Prescription Drug Plan Quality Rating System

*Contract Consolidation*

NCOA is encouraged by CMS’ proposal to address the impact contract consolidation has on star ratings. As CMS indicates, as a result of contract consolidation, reported performance for the contract as a whole may not be representative of local geographical performance or of the number of enrollees in the entire contract. This lessens the reliability of Star Ratings as an indicator of true quality for beneficiaries. Additionally, health plans can potentially manipulate the system for higher Star Ratings and bonus payments. This issue persists for approximately two years before the measurements in Star Ratings more accurately reflect combined data from the cross-walked plans.

However, it is important to note that CMS’ proposal is a short-term solution that does not fully address the problems caused by contract consolidation. While being a better reflector of quality than the status quo in contract consolidations, the averaging method would only give a truly accurate picture of quality in a given geographic area if the two or more contracts involved in a given consolidation shared exactly the same service area. According to MedPAC, of the 17 contract consolidations where a plan with less than four stars was consumed by a plan with more than four stars, only one involved an overlap of service area.[[9]](#footnote-9)

Additionally, the averaging method would continue to provide an incentive for organizations to use contract consolidation as a means of obtaining unwarranted bonus payments. For example, two contracts with equal enrollment, one with a 4.5-star rating and one with a 3.5-star rating, could be combined to result in what would likely be a 4-star rating of the consolidated contract. The averaging method solves the problems caused by many types of combinations that have occurred in the past, but it does not fully address the concern about unwarranted program expenditures or inaccurate information provided to beneficiaries. Further, CMS’ suggestion to allow leeway in quality bonus payments to two plans that are consolidated under one parent organization, would further lead to unwarranted program expenditures.

Thus, while the move to average star ratings of two consolidated contracts would partially address the misrepresentation of quality caused by contract consolidation, NCOA encourages CMS to continue to explore longer term solutions which would truly remove any incentive for plans to consolidate simply to increase bonus payments or mispresent quality to beneficiaries.

Expedited Substitutions of Certain Generics and Other Midyear Formulary Changes

NCOA is concerned by CMS’ proposal to allow midyear generic substitutions without advance notice to beneficiaries. The proposal suggests that plans could provide beneficiaries with a generalized advance notice (warning beneficiaries that such substitutions could happen), and then provide retrospective notice on the specific changes. This is problematic because the current 60-day notification allows the beneficiary time to understand how a generic drug would affect their treatment regimen. Without notification, a change in cost sharing and the pill size, shape, and color would cause undue stress on beneficiaries-regardless of whether their treatment regimen could withstand a change to generic drugs. This in turn could affect medication adherence. Ample direct notification, even if it were 45 days, is best for beneficiaries.

Treatment of Follow-On Biological Products as Generics

NCOA supports CMS’ proposed revision of the definition of generics to include biosimilars for purposes of cost sharing. Encouraging the use of biosimilars among LIS beneficiaries and non-LIS enrollees with very high spending could spur greater price competition among biological products, expand access for beneficiaries, and help to restrain growth in program spending.

Eliminating the Requirement to Provide PDP Enhanced Alternative (EA) to EA Plan Offerings with Meaningful Differences

NCOA is concerned by CMS’ proposal to eliminate the meaningful differences requirement between two enhanced alternative PDP offerings. Just as with the meaningful differences requirement for MA plans, this requirement prevents an unnecessary increase in complexity for beneficiaries who are shopping for Medicare plans. Beneficiaries already choose from an average of 23 Part D standalone plans.[[10]](#footnote-10) As with Medicare Advantage plans, beneficiaries are similarly confused by Part D plans. In NCOA’s recent in-person beneficiary interviews regarding Medicare’s Plan Finder tool, beneficiaries did not understand terms such as pharmacy status, tiering, or medication therapy management, and how these different factors affect out-of-pocket costs. Given the confusion that beneficiaries face when navigating Part D plans, it is crucial that CMS continue to limit plan sponsors to offering no more than two EA plans in each region.

CMS suggests that the repeal of this meaningful difference requirement is necessary for plan sponsors to add a second EA plan in regions that only have one EA plan offering. We urge CMS to share data that suggests the meaningful difference requirement is in fact preventing innovation by plans.

As an alternative to repealing the meaningful difference requirement between two EA plans, CMS could consider a waiver of the meaningful difference requirement only in cases where plan sponsors can show that there are significant differences in value between their EA offerings even when the difference in expected out-of-pocket costs do not exceed the minimum threshold. Even in those cases, it would be imperative for CMS to remain vigilant in ensuring that “differences in plan characteristics and benefit designs” reflect significant differences in value and that beneficiaries can evaluate and compare their options in an informed manner.

We support CMS’s proposal to continue use of the meaningful difference requirement between basic and EA plans. Eliminating this requirement could result in sponsor behaviors that could adversely affect the program, such as offering EA plan options that result in adverse selection. By enrolling healthier beneficiaries into certain EA plans, plan sponsors could segment higher cost enrollees into plans with higher premiums for basic benefits. To the extent that the basic plan qualifies as an LIS benchmark plan, it could increase the amount Medicare pays for the low-income premium subsidy. Given this potentially adverse impact on the program, and the added complexity it would cause for beneficiaries, it is important to continue to distinguish between basic and EA plans, as well as to limit the number of plans offered in each region.

Request for Information Regarding the Application of Manufacturer Rebates and Pharmacy Price Concessions to Drug Prices at the Point of Sale

NCOA is encouraged by CMS’ proposal to pass through a percentage of manufacturer rebates and pharmacy price concessions to drug prices at the point of sale. A November 2016 Milliman report concluded Part D plans have a financial incentive to cover drugs with higher list prices and higher rebates as a means of driving down the premium, compared to lower price drugs with lower rebates.[[11]](#footnote-11) Moreover, because benefit designs have shifted more to coinsurance for brand drugs (based on the list price), beneficiaries who take medications with high rebates are not benefitting financially from those higher rebates.  Thus, these embedded incentives result in increased costs to both the government and beneficiaries.

In January 2017, CMS also released a memorandum examining direct and indirect remuneration (DIR) in Part D, which reached the same conclusion.[[12]](#footnote-12) In that report, CMS notes that DIR increases are not resulting in lower Part D plan premiums, even though plans are required to pass rebates through to beneficiaries in the form of lower premiums. The fact that the incentives of Part D allow and, even encourage, a system of drug pricing and rebating that shifts spending increasingly to beneficiaries and the federal government is of great concern to NCOA. By passing through a percentage of rebates and pharmacy price concessions to beneficiaries at the point of sale, CMS can work towards achieving the important goal of price transparency for beneficiaries, while overall saving spending for both beneficiaries and the federal government.

CMS should determine the percentage of rebates and pharmacy price concessions to pass through using a strong evidence base. CMS suggests that rather than pass through a percentage of rebates to all drugs that include rebates, they would consider only applying a percentage of rebates to specific drugs at the point of sale. NCOA prefers that CMS develop a proposal which applies to all drugs that carry manufacturer rebates.

It is important to note that while this proposal could lead to lower cost sharing for beneficiaries, this does not solve the complexities of drug pricing. For example, this proposal does not help beneficiaries who take expensive drugs with no post-sale rebates or discounts. NCOA encourages CMS to consider multiple options to address the high costs of drugs that beneficiaries experience.

Revisions to Timing and Method of Disclosure Requirement

NCOA applauds CMS’ proposal to separate the mailings of the Annual Notice of Change (ANOC) and Evidence of Coverage (EOC). This simple change will allow beneficiaries to examine the documents separately rather than be overwhelmed by them in the same mailing, and in particular, encourage beneficiaries to focus on the information contained in the ANOC. It is crucial that the ANOC continue to be delivered at least 15 days before open enrollment, to allow beneficiaries sufficient time to understand changes to their current health insurance, so they can make a compare other plan options and change if they desire.

However, NCOA is very concerned about the proposal to increase electronic delivery of important beneficiary documents, by requiring beneficiaries to opt out of electronic delivery if they want a paper copy of certain items. According to a recent Pew study, only half of older adults have broadband at home, and a third of older adults don’t use the internet. Access to broadband and usage of the internet also varies with age. Technology usage decreases substantially above the age of 75. Technology adoption also varies substantially with income. For example, while 87% of seniors earning more than $75,000 per year have broadband at home, only 27% of seniors who earn less than $30,000 per year have access to broadband at home. Further exacerbating these issues is the level of confidence older adults have in technology. For example, 34% of those who do use the internet report having little or no confidence in their ability to perform online tasks.[[13]](#footnote-13)

Thus, a significant portion of older adults would not be able to access the documents under consideration for electronic access only. Changes in net neutrality rules may also lead to slower Internet connections for beneficiaries. In particular, documents such as the provider directory are crucial for a beneficiary to make a decision when shopping for a health care plan, or understanding which providers are in a plan network when making any health plan decisions.

We appreciate the interest in going paperless and support an eventual move in this direction, when more of the population has access to broadband. To encourage fewer paper deliveries, CMS should instead allow beneficiaries to opt-in to electronic delivery- but paper delivery would still be the default method of delivery. For the EOC specifically, CMS might also consider only sending portions of the document that change each year on paper-and allowing electronic delivery of chapters that remain unchanged. These options would balance the need for more efficient delivery of documents with the needs of beneficiaries.

We also would like to reiterate the importance of continuing to send the ANOC as a paper document. This is one of the most important documents beneficiaries have at their disposal, and it is imperative that all beneficiaries continue to have easy access to the document.

As noted when considering the changes that are needed before repealing the meaningful differences requirement, improvements to the ANOC are long overdue. We continue to advocate for an individualized MA and Part D ANOC to better serve individual beneficiary needs. At a minimum, we suggest that CMS solicit input from multiple stakeholders on recommendations to improve the ANOC, EOC, and other standardized materials used during the annual election period.

Revisions to Parts 422 and 423, Subpart V, Communication/Marketing Materials and Activities

We appreciate the need to appropriately classify materials for marketing purposes or otherwise. However, we are concerned that many materials which need oversight by CMS, regardless of their classification, would not have rigorous oversight under this proposal. CMS needs to maintain standards for all documents that target beneficiaries, whether they involve marketing, education, or another type of communication. Beneficiaries need to make informed decisions not just about enrollment, but about maintaining enrollment and using their insurance benefits in the health care system. We ask CMS to provide more guidance on which documents they would consider reclassifying, and how they intend to maintain rigorous oversight for all beneficiary documents.

Lengthening Adjudication Timeframes for Part D Payment Redeterminations and IRE Reconsiderations

NCOA is concerned about CMS’ proposal to lengthen the timeframe for adjudication of decisions from Part D sponsors and the IRE. Lengthening the timeframe would have important negative consequences for beneficiaries. In cases that are appealed to the IRE, existing deadlines provide enrollees with a decision within a total of 17 days from initial appeal. The proposed policy would add 14 days for a total of 31 days. Given that many Medicare beneficiaries are on limited budgets (e.g., on average, Social Security benefits account for more than 60 percent of income for seniors; for more than one-fifth of seniors, Social Security benefits account for 100 percent of income), we are concerned about the increased financial burden this proposal would place on beneficiaries. Beneficiaries who wait up to a month to then learn that their case has been decided against them, would have to either pay for the drug out of pocket again or get a prescription for an alternative drug within a short time period. These options jeopardize enrollees’ access to needed drugs, either initially prescribed or alternative, in a timely manner.

Elimination of Medicare Advantage Plan Notice for Cases Sent to the IRE

NCOA is concerned about CMS’ proposal to eliminate the MA plan notice for cases sent to the IRE in an appeal. Beneficiaries receive a deluge of mail related to Medicare – and they are much more likely to open a notice from their plan than from the IRE (an organization for which they may not know). Thus, eliminating this notice could lead to beneficiary confusion about the status of their appeal. If CMS wants to limit duplication of effort, it would be better to delay the timing at which the IRE sends a notice to beneficiaries.

Thank you again for this opportunity to share our comments. If you have any questions or if we can be of any further assistance, please contact Samantha Zenlea at [Samantha.Zenlea@ncoa.org](mailto:Samantha.Zenlea@ncoa.org).

Sincerely,

Samantha Zenlea

Senior Regulatory Policy Specialist

1. Public Law No: 114-198, SEC. 704. PROGRAMS TO PREVENT PRESCRIPTION DRUG ABUSE UNDER MEDICARE PARTS C AND D (a) Drug Management Program for At-Risk Beneficiaries [↑](#footnote-ref-1)
2. 2016 Part C and Part D Program Audit and Enforcement Report  [↑](#footnote-ref-2)
3. Jacobson, G, Damico, A., and Neuman, T. Medicare Advantage 2018 Data Spotlight: First Look. Available at: <https://www.kff.org/medicare/issue-brief/medicare-advantage-2018-data-spotlight-first-look/> [↑](#footnote-ref-3)
4. *The Evidence is Clear: Too Many Health Insurance Choices Can Impair, Not Help Consumer Decision Making;* Lynn Quincy and Julie Silas; Consumers Union, November 2012 (<http://consumersunion.org/wp-content/uploads/2012/11/Too_Much_Choice_Nov_2012.pdf>) [↑](#footnote-ref-4)
5. *Cognitive Functioning and Choice between Traditional Medicare and Medicare Advantage;* [J. Michael McWilliams](http://www.ncbi.nlm.nih.gov/pubmed/?term=McWilliams%20JM%5Bauth%5D), [Christopher C. Afendulis](http://www.ncbi.nlm.nih.gov/pubmed/?term=Afendulis%20CC%5Bauth%5D),, [Thomas G. McGuire](http://www.ncbi.nlm.nih.gov/pubmed/?term=McGuire%20TG%5Bauth%5D), and [Bruce E. Landon](http://www.ncbi.nlm.nih.gov/pubmed/?term=Landon%20BE%5Bauth%5D);Cognitive Functioning and Choice between Traditional Medicare and Medicare Advantage

   Health Affairs, September 2011 (<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3513347/>) [↑](#footnote-ref-5)
6. *What’s Behind the Door: Consumers’ Difficulties Selecting Health Plans;* Lynn Quincy; Consumers Union, January 2012 (<http://consumersunion.org/wp-content/uploads/2013/03/Consumer_Difficulties_Selecting_Health_Plans_Jan2012.pdf>) [↑](#footnote-ref-6)
7. Ibid. [↑](#footnote-ref-7)
8. *Medicare Advantage: Options for Standardizing Benefits and Info to Improve Consumer Choice;* Ellen O’Brien and Jack Hoadley; The Commonwealth Fund, April 2008 (<http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2008/Apr/Medicare%20Advantage%20%20Options%20for%20Standardizing%20Benefits%20and%20Information%20to%20Improve%20Consumer%20Choice/OBrien_Medicare_Advantage_options_1117_ib%20pdf.pdf>) [↑](#footnote-ref-8)
9. *MedPAC comment letter on CMS-4192-P.* January 2018. <http://medpac.gov/docs/default-source/comment-letters/01032018_partc_d_comment_v2_sec.pdf?sfvrsn=0>. [↑](#footnote-ref-9)
10. Cubanski, J., et al. Medicare Part D: A First Look at Prescription Drug Plans in 2018. Available at <https://www.kff.org/medicare/issue-brief/medicare-part-d-a-first-look-at-prescription-drug-plans-in-2018/>. [↑](#footnote-ref-10)
11. Barnhart, AJ and Gomberg J. Financial incentives in Medicare Part D. The AIDS Institute. Available at <http://theaidsinstitute.org/sites/default/files/attachments/Milliman%20Report%20-%20Final.pdf> [↑](#footnote-ref-11)
12. Centers for Medicare and Medicaid Services. Medicare Part D-direct and indirect remuneration. Available at <https://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2017-fact-sheet-items/2017-01-19-2.html> [↑](#footnote-ref-12)
13. Pew Research Center, May 2017, “Tech Adoption Climbs Among Older Adults.” [↑](#footnote-ref-13)