* Part D Tiering Exceptions
  + Medicare has not standardized tiering pretty much allowing plans to put drugs into whatever tiers it wants. So what is to keep plans from moving expensive brand name drugs to specialty tiers to avoid having to make exceptions. I would recommend that as a first step, CMS require standardization of tiers, such as all generic drugs must be placed in either tier 1 (preferred) or tier 2 (non-preferred), etc. Then they could move forward with this step.
  + The proposed tiering rules say that brands would be assigned to the lowest cost-sharing tier associated with brand alternatives and generics would be assigned to the lowest cost-sharing tier associated with generic alternatives. This doesn’t really offer much assistance to a person who must take a brand name drug, which may be a tier 3 drug, out of medical necessity. The exception should be that they could receive the brand name drug for the same copayment as the generic drug they are unable to take.
* Apply Manufacturer Rebates and Pharmacy Price Concessions to Drugs at the Point of Sale – No comment on this. I believe the issue is too complex for me to comment effectively
* Mid-Year Formulary Changes/Expedited Substitutions of Generics
  + Because new generics generally are not substantially less expensive that brand-name drugs, what would be the benefit of this change?
* Adjudication Timeframes for Payment Redeterminations
  + One of the analyses, from AmerisourceBergan, erroneously reported that this was to reduce the timeframe. However the Avalere analysis states it as an extension of time from seven to 14 calendar days for issuing decisions on payment redeterminations from the date that the sponsor receives the request. This is described as easing the sponsor burden. While this works more to the benefit of the plan that the beneficiary one would be reasonable to ask how the beneficiary would benefit from this, as the process is designed to prevent the beneficiary from paying for something that the plan should be paying for. How will the plans “compensate” the beneficiary for having to wait longer? Lower premiums? If the intent is to reduce the percentage of these requests that are considered not being done on time, then one could argue that moving the bar doesn’t equate to an improvement in the situation and CMS should be careful not to cause hardship for a beneficiary for the benefit of the plan or the IRE.
* Limitations on Part D Special Enrollment Periods for Duals
  + What is the likely impact? One obvious impact would be that plans will have lower costs due to less paperwork and fewer person-hours spend making the changes. There is evidence that few people make changes during the year, even though they have the ability to do so. Our SHIP usually explains this option as a benefit if someone is prescribed a drug not covered under their current plan. If a plan can be identified that would cover the drug, they could move to it and greatly benefit from not having to pay full price for a non-covered drug. If this proposed part of the rule were to be adopted, it is recommended that there be provisions that would provide for exceptions for uncovered drugs so that they would not have to pay full price for non-formulary drugs.
* Advantage Plan MOOP Changes and Cost-Sharing Limits for Parts A and B
  + I agree with the implication statement from Avalere. With so few people reaching MOOP, it appears that if higher cost-sharing is allowed it may skew toward higher costs for beneficiaries with negligible overall benefits.
* Passive Enrollment Flexibilities for Duals
  + I definitely support the plan to have a minimum of a 3 star overall rating for any plans to which a beneficiary could be passively enrolled.
  + While this proposed rule change would allow beneficiaries to enroll in a different plan within two months, it is extremely important that beneficiaries be made aware of the right to do so. In Idaho, many dually eligible person are in care facilities and they may not be aware of their rights in this situation. Also, if anyone has chosen to have just Medicare and not be enrolled in a Medicare Advantage plan, they should not be passively enrolled into a MA plan.
* Flexibility in MA Uniformity Requirements
  + This may be better as a pilot to develop evidence of the effectiveness of the program, rather than rolled out directly, given concerns about how CMS will monitor for nondiscrimination.
* Communication/Marketing Materials
  + While reducing oversight of certain plan materials *might* allow CMS to focus efforts on the most “influential” materials, it would be a mistake for CMS to exclude summaries of benefits, subscriber agreements and member handbooks from scrutiny, as these are the documents that provide beneficiaries the facts of their coverage. CMS needs to be sure this information is accurate and clear enough to be understood by beneficiaries.