

March 4, 2022

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington DC, 20201

RE: CMS-4192-P

Dear Ms. Brooks-LaSure:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) notice of proposed rulemaking entitled “Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs,” published in the *Federal Register*, vol. 87, no. 8, pp. 1842–1960. We appreciate your staff’s work on the notice, particularly considering the competing demands on the agency.

This proposed rule includes several provisions that would revise regulations for the Medicare Advantage (MA) program (Part C) and the Prescription Drug Benefit program (Part D). Our comments focus on the following provisions:

- Refining definitions for fully integrated and highly integrated dual-eligible special needs plans (D–SNPs)
- Attainment of the maximum out-of-pocket (MOOP) limit
- Special requirements during a disaster or emergency
- Proposed regulatory changes to Medicare medical loss ratio reporting requirements and release of Part C medical loss ratio data
- Pharmacy price concessions in the negotiated price

Refining definitions for fully integrated and highly integrated D–SNPs

D–SNPs are specialized MA plans that limit their enrollment to beneficiaries who receive both Medicare and Medicaid. Under the Bipartisan Budget Act of 2018 (BBA), all D–SNPs must meet one of three standards for integrating the delivery of Medicare and Medicaid services:

- *Coordination-only D–SNPs* notify states about admissions to inpatient hospitals and skilled nursing facilities for at least one group of high-risk full-benefit dual-eligible beneficiaries, as defined by the state.
- *Highly integrated dual-eligible SNPs (HIDE–SNPs)* have capitated Medicaid contracts to provide long-term services and supports (LTSS), behavioral health, or both.
- *Fully integrated dual-eligible SNPs (FIDE–SNPs)* have capitated Medicaid contracts to provide a broad range of services that includes both LTSS and behavioral health.

Coordination-only plans have the lowest level of integration because they do not have to provide any Medicaid services, while FIDE–SNPs have the highest level of integration because they provide the broadest range of Medicaid services. HIDE–SNPs provide varying levels of integration between those extremes.

The proposed rule would modify the FIDE–SNP and HIDE–SNP definitions to better distinguish them and improve their integration with Medicaid:

- FIDE–SNPs would be required to provide all Medicaid services in several areas—primary care, acute care, Medicare cost sharing, home health, durable medical equipment, and behavioral health. Starting in 2025, FIDE–SNPs would also have to use exclusively aligned enrollment, which limits enrollment in the plan to Medicare beneficiaries who are eligible for full Medicaid benefits and receive those benefits from the same parent organization.
- Plans that qualify as HIDE–SNPs by providing Medicaid behavioral health services would be required to provide the full range of those services. Starting in 2025, the service areas for HIDE–SNPs would also need to be completely within the service areas for their companion Medicaid plans (i.e., the plan would not qualify as a HIDE–SNP if it operated in any counties where its sponsor did not have a Medicaid managed care plan).

CMS would also codify existing guidance that allows FIDE–SNPs and HIDE–SNPs to have limited carve-outs from their coverage of Medicaid LTSS and behavioral health.

Comment

We support the proposed changes to the FIDE–SNP requirements and believe they will help ensure that those plans are, in fact, fully integrated with Medicaid and make it easier for beneficiaries to understand how they differ from other, less integrated D–SNPs.

We also support the proposed changes to the HIDE–SNP requirements as an incremental step towards greater integration, but we suggest that CMS consider requiring these plans to have exclusively aligned enrollment, similar to the proposed requirement for FIDE–SNPs. We believe that HIDE–SNPs are intended to be more highly integrated than coordination-only plans because they must have a capitated Medicaid contract to provide LTSS and/or behavioral health. However, this integration will not occur for beneficiaries who enroll in one company’s HIDE–SNP for their

Medicare benefits and another company's Medicaid plan for their LTSS and/or behavioral health benefits. These beneficiaries with misaligned enrollment do not appear to benefit from any of the BBA's integration requirements.

Requiring HIDE-SNPs to use exclusively aligned enrollment would prevent this situation from occurring. The extent to which this requirement would improve integration would depend on states and plan sponsors, who could either adopt exclusively aligned enrollment so the existing HIDE-SNPs continue to keep that designation or instead let those plans meet the lower coordination-only standard for integration. The use of exclusively aligned enrollment would also entail some disruption for full-benefit dual-eligible beneficiaries who are enrolled in HIDE-SNPs but have misaligned enrollment, as well as for any partial-benefit dual-eligible beneficiaries who are now enrolled in a HIDE-SNP. However, requiring HIDE-SNPs to use exclusively aligned enrollment could enable CMS to implement a range of policies that promote integration (such as requiring more D-SNPs to have Medicaid contracts to cover Medicare cost sharing, integrated member materials, and a unified process for handling appeals and grievances) on a wider scale.

Finally, we support allowing FIDE-SNPs and HIDE-SNPs to have limited carve-outs of LTSS and behavioral health services given the wide variation in how states choose to provide those services. However, given the potential benefits of greater integration, we encourage CMS to limit the use of carve-outs where possible.

Attainment of the MOOP limit

Since 2011, CMS has required all MA plans to have a MOOP limit on cost sharing for Part A and Part B services. This limit cannot exceed a dollar amount specified by CMS, which for 2022 is \$7,550. (For local and regional preferred provider organizations, that limit applies to in-network care; another limit applies to combined out-of-pocket costs for both in- and out-of-network care.) Plans have the option of using a lower MOOP limit. Once enrollees reach the MOOP limit, the MA plan covers their cost sharing for the rest of the year.

Plan sponsors differ in how they administer the MOOP limit for dual-eligible beneficiaries. Some plans administer the limit based on the enrollee's total cost-sharing liability, while other plans use the cost sharing that was actually paid by the enrollee. Since Medicaid limits beneficiary cost sharing to nominal amounts, dual-eligible beneficiaries enrolled in plans that use the second approach never reach the MOOP limit. CMS proposes requiring all MA plans to administer the MOOP limit based on an enrollee's total cost-sharing liability.

Comment

We support the proposal. Plan sponsors should administer the MOOP limit in a consistent manner for all MA enrollees. Dual-eligible beneficiaries in plans that now use the more restrictive approach may also benefit from better access to care because providers will receive higher payments for treating them once they have reached the MOOP limit. (States can base their payments for Medicare cost sharing for dual-eligible beneficiaries on either the Medicare rate or the Medicaid rate for a given service, and most states use the lesser of the two amounts. Since

Medicaid rates are often lower than Medicare rates, this means that states often pay only a portion of the Medicare cost sharing for a dual-eligible beneficiary, and in many cases may pay nothing. Providers in these “lesser of” states thus receive lower payments when they serve dual-eligible beneficiaries.)

Special requirements during a disaster or emergency

Under current regulation (§ 422.100(m)), MA organizations are responsible for ensuring that MA enrollees continue to have access to care when normal business operations are disrupted and that out-of-network providers are informed of the terms of payment for furnishing services to affected enrollees during disasters or emergencies, including public health emergencies (PHEs). The regulation acknowledges that disasters and emergencies can be declared by the President, the Secretary, or state governors. Under disaster or emergency declarations, organizations must follow certain special requirements, including covering all plan services at non-contracted providers, waiving requirements for gatekeeper referrals, providing in-network levels of cost sharing for out-of-network services, and applying these changes immediately. These special requirements must be applied in affected plan service areas from the initial declaration of a disaster or emergency through the end as declared by the appropriate authority, or 30 days after the initial declaration if no end date was identified.

After the coronavirus PHE was declared, CMS received questions about the applicability of the special requirements, prompting a review of the regulations and the laws related to disasters and emergencies. CMS now proposes to limit the application of the special requirements to periods when there is a disruption in access to health care, defined as an “interruption or interference in access to health care throughout the service area such that enrollees do not have the ability to access contracted providers or contracted providers do not have the ability to provide needed services causing MA organizations to fail to meet the prevailing patterns of community health care delivery in the service area.” CMS identifies a range of interruptions or interferences including those that may be physical (e.g., transportation difficulties, power outages) and those caused directly by the disaster or emergency (e.g., lack of available hospital beds, closed health care facilities due to quarantine restrictions). The proposal is intended “to ensure that this regulation is not overly broad and is appropriately tailored to address our concerns that MA enrollees have adequate access to medically necessary care and are not unduly restricted to the MA plan’s network of providers.” CMS cites the emergency declared by the Hawaiian governor to fight the Zika virus and the Opioid PHE declared by the Secretary as examples of emergencies without an associated disruption in access to health care. Under the coronavirus PHE, disruptions to health care access have varied across the country and over time.

Further, CMS proposes that MA organizations initially be responsible for evaluating whether there is a disruption to health care access, and asserts that MA organizations are best positioned to make such an evaluation. CMS would monitor MA organizations’ application of the special requirements; if the agency discovers problems with health care access for MA plan enrollees, it will direct MA organizations to comply with regulations appropriately. MA organizations would continue to be required to meet network adequacy standards or apply the special requirements. If

special requirements are applied, they would continue for 30 days after the health care access disruption ends as determined by MA organizations.

CMS also proposes technical adjustments that would clarify when the application of special requirements would end under one or more disasters or emergencies, and under disasters or emergencies of different declaration authority.

Comment

We agree with CMS's assessment that the application of special requirements is not sufficiently targeted under current regulations, and that it may be appropriate to limit the special requirement application to disruptions in health care access. The special requirements limit MA plans' key tools for constraining Medicare costs: limiting payments or imposing higher cost sharing for out-of-network services and applying restrictions to referral policies.

Although we agree that it is appropriate to limit the special requirements application to disruptions in health care access, we are concerned that authorizing plans to identify such disruptions and apply the special requirements appropriately does not sufficiently guarantee beneficiary protections. When access to care is disrupted, it is imperative that MA plans ensure, through the special requirements, that beneficiaries receive needed care to the extent possible. This regulation, under the subpart title "Benefits and Beneficiary Protections," should prioritize protecting beneficiaries from access disruptions over avoiding undue limitations on MA plans' tools to constrain costs. Under CMS's proposal, MA organizations, which have a financial incentive not to apply the special requirements, would be the actors deciding when special requirements are appropriate. Medicare beneficiaries in the midst of a disaster or emergency should not face the question of whether their plan is applying the special requirements in accordance with regulation.

Further, we are concerned that the determination of access will vary across MA organizations in a service area or that MA organizations will determine different durations for a disruption. In most service areas, multiple MA organizations offer MA plans, allowing for the possibility that MA organizations will differ in determining whether there has been an access disruption, as they may use different standards for determining when an access disruption exists or had concluded. Differing standards would lead to inequities in the treatment of enrollees in the same area across MA organizations. Even if CMS discovers that some MA organizations are not applying special requirements in a service area where health care access disruptions exist, the delay caused through CMS's discovery and subsequent directions to apply the special requirements could be detrimental to the affected Medicare beneficiaries.

CMS asserts that plans are best positioned to evaluate disruptions in health care access because they know the status of providers' operations and are in communication with providers. Effectively, the providers would be the source of information used to determine whether there is an access disruption. Many physician groups, health systems, and providers of all types contract with multiple MA organizations; under the proposal, amidst a disaster or emergency, these providers would need to communicate with numerous MA organizations in order for special requirements to be applied for affected MA enrollees. CMS also notes that access disruptions can be caused by

failures of non-health care infrastructure, including transportation difficulties and power outages; however, the agency does not state how it would evaluate those situations or why MA organizations are best situated to make such evaluations.

For these reasons (unaligned incentives for plans, variation in MA organizations' determination of access disruptions and their duration, the burden placed on providers as a source of information about disruptions, and plans responsibility for tracking non-health-care-based disruptions), we believe CMS should retain responsibility for determining when the special requirements should be applied under declared disasters and emergencies. We recognize that this adds administrative burden to CMS; however, we submit that CMS is best positioned to properly prioritize beneficiary protections while avoiding overly broad application of the special requirements, and could do so without too much administrative effort using a hybrid approach.

Under the current standard, MA organizations must apply the special requirements for the full duration of all disasters and emergencies. Under CMS's proposed standard, MA organizations would be responsible for determining whether an access disruption exists and applying the special requirements appropriately for all disasters and emergencies.

Under a hybrid approach, CMS could keep the current standard as the default for all disasters and emergencies, but the Secretary could choose to apply the proposed standard instead on an as-needed basis. For example, the emergency to fight Zika or the Opioid PHE may be opportunities to apply the standard being proposed by CMS. Also, if the current standard is in place and the disruption to health care access ends before declared disaster or emergency, the Secretary could choose to apply the proposed standard at that point.

In addition, when the proposed standard is in place, CMS should track MA organizations' application of the special requirements and take an active role in ensuring that the special requirements apply equally to all MA enrollees in a local area. For example, if at least one MA organization operating in a service area applies the special requirements, CMS should require that all MA organizations operating in that service area apply the special requirements. MA organizations failing to apply the special requirements when they are necessary is a major concern. Using a threshold for requiring all MA organizations to apply the special requirements can be effective in limiting the effects of bad actors when there are multiple MA organizations operating in an area. CMS should pay special attention to disasters and emergencies in areas with only one MA organization operating and ensure that beneficiary protections are maintained appropriately.

We think such a system would appropriately prioritize beneficiary protections, while reducing the unnecessary application of special requirements when health care access has not been disrupted. Furthermore, a service area threshold requirement for all MA organizations to apply the special requirements would provide an important beneficiary protection that is missing from CMS's proposal.

Proposed regulatory changes to Medicare medical loss ratio reporting requirements and release of Part C medical loss ratio data

For each MA and Part D contract, a medical loss ratio (MLR) represents the percentage of revenue (as defined under §§ 422.2420(c)) used for patient care (as defined under §§ 422.2420(b)). If CMS determines that an MA contract has an MLR of less than 85 percent, the MA organization must remit to CMS any revenues equivalent to the difference between a plan's MLR and an MLR of 85 percent. MA contracts that fail to meet the MLR threshold for three consecutive years are prohibited from enrolling additional beneficiaries in the year following CMS's determination. Failure to meet the threshold for five consecutive years results in contract termination.

CMS determines MLRs using aggregate data submitted by MA contracts. From 2014 to 2017, plans were required to submit aggregate revenue and spending amounts by category (e.g., incurred claims for Medicare benefits, quality improvement activities) that helped CMS verify the accuracy of MLR remittances. However, starting in 2018, CMS attempted to alleviate the administrative burden of MLR data submissions and reviews by requiring an MA contract to submit only its overall MLR and total remittance. Without the underlying data, CMS subsequently found that both the number of contracts flagged during agency reviews of MLR data and the number of contracts submitting corrections to errors in MLR calculations plummeted. CMS concluded that this change in policy likely leads to less accurate MLR data and fewer overall remittances collected.

CMS proposes to reinstate the original requirement for plans to submit more detailed MLR data and additionally require plans to submit spending separately for each non-medical supplemental benefit category (e.g., vision, hearing, dental, fitness, worldwide travel, meals, special benefits for the chronically ill). CMS believes that these changes will result in greater transparency for beneficiaries and the public and will generate more accurate remittances. CMS estimates that this policy will result in additional remittances of \$268.6 million over 10 years while increasing MA administrative costs by just \$2.3 million annually.

In addition, CMS seeks comment on whether plans should be required to separately identify spending for supplemental coverage that extends or reduces the cost sharing for items and services covered under Part A and Part B. CMS is concerned that it would be exceedingly difficult for MA plans to separately identify and track spending on extended coverage of original Medicare benefits and cost-sharing reductions, although this information is separately identified by plans when they submit bid data annually.

Comment

We support CMS's efforts to increase transparency in the MA program, including the requirement for MA plans to submit spending amounts for non-medical supplemental benefit categories. Nearly half of all eligible Medicare beneficiaries are now enrolled in an MA plan, but spending and utilization data for MA enrollees is limited. While MA plans are required to submit encounter data for Medicare beneficiaries enrolled in MA plans, the Commission has found that MA encounter

data are not sufficiently complete to inform improvements to MA payment policy.¹ Despite the lack of these data, MA plans receive higher payments relative to what Medicare fee-for-service (FFS) spending would have been for similar beneficiaries.² These extra payments from the Medicare program have increasingly financed MA plans' ability to offer non-medical supplemental benefits (including plan administrative expenses and profit), but data on the use of these benefits is not available.³ Increased transparency for the spending related to non-medical supplemental benefits would clearly benefit the Medicare program and its beneficiaries.

In addition, given that MA plan bids separately identify and submit spending on extended coverage of original Medicare benefits and cost-sharing reductions, we believe it would be reasonable to require plans to separately report spending for these supplemental benefits. Beneficiaries rely on MA plans correctly ensuring that overall cost sharing levels do not exceed what would be expected in FFS. Further, MA enrollees rely on MA plans providing supplemental coverage in lieu of Medigap coverage. Therefore, MA plans should reasonably be able to estimate how much plan rebate dollars are allocated toward this coverage.

Pharmacy price concessions in the negotiated price

Unlike health plans for commercial payers and employers, Part D plan sponsors cannot use exclusive pharmacy networks. By law, sponsors must permit within their networks any pharmacy that is willing to accept the sponsors' terms and conditions. However, plan sponsors may include terms in their network contracts that include postsale price concessions contingent on pharmacy performance. Examples of such terms include periodic payment reconciliations related to drug reimbursement rates and fees that are assessed on measures that are set by the sponsor or its pharmacy benefit manager (PBM). Plan sponsors and their PBMs argue that payment adjustments based on performance metrics help hold pharmacies accountable for the value and quality of their services.⁴ Meanwhile, some pharmacies contend that such postsale fees are not transparent, are based on performance goals that can be unobtainable, and have made final reimbursements from plan sponsors lower and less predictable.⁵

Currently, CMS requires that "negotiated prices" of drugs—that is, reimbursement amounts negotiated between plan sponsors and their network pharmacies—include all pharmacy price concessions except those that cannot reasonably be determined at the point of sale. Because performance-based payment adjustments are typically assessed postsale, they are not included in

¹ Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

² Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

³ Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

⁴ Examples of some measures used include generic dispensing rates, patient adherence rates, and medication therapy management completion rates.

⁵ For example, independent specialty pharmacies have said they are evaluated on rates of statin dispensing—a drug class they often do not dispense. Payments to some community pharmacies are reconciled based on rates of dispensing generics measured at the level of the pharmacy services administrative organization they use rather than for their individual pharmacy.

negotiated prices; instead, they are reported to CMS as direct or indirect remuneration (DIR) and are commonly referred to as “pharmacy DIR.” CMS takes pharmacy DIR, as well as other types of DIR (including manufacturer rebates), into account for Medicare’s final payments to Part D plans. According to CMS data, while rebates make up the largest category of DIR, pharmacy DIR has grown much more rapidly. Between 2013 and 2020, pharmacy DIR grew by an average of 70 percent per year, from \$228 million to \$9.5 billion.⁶ By 2020, pharmacy DIR accounted for about 18 percent of all DIR, up from less than 2 percent in 2013.

The current magnitude of pharmacy DIR has a material effect on how much Part D enrollees pay out of pocket at the pharmacy counter. When enrollees pay cost sharing in the deductible phase or based on a percentage coinsurance of the negotiated price before postsale fees are assessed, those cost-sharing amounts are a higher share of the drug’s final costs than the enrollee’s stated share. In addition, because Part D rules require that plans’ fixed-dollar copayments be at least actuarially equivalent to the coinsurance required under the defined standard benefit, copayment amounts are also higher. Because Part D’s low-income subsidy (LIS) covers most cost-sharing obligations for LIS enrollees, pharmacy DIR also contributes to higher Medicare spending on low-income cost-sharing subsidies. High cost sharing also moves enrollees more quickly through Part D’s benefit phases into the catastrophic phase in which Medicare pays 80 percent of prescription costs.

Plan sponsors submit expected amounts of DIR as part of their Part D bids, which is used to lower premiums. However, in recent years, the amount of DIR that sponsors received consistently has exceeded the amount that sponsors projected in their bids. CMS points out that under Part D’s risk corridors, the larger amounts of DIR have contributed primarily to plan profits, not lower premiums. The agency states that “when a plan underestimates the amount of DIR that it will receive, any additional amount of DIR constitutes additional plan revenues. In the event that overall plan revenues exceed the amount projected in the plan sponsor’s bid, the sponsor is permitted to retain most, if not all, of the excess amount, assuming that the sponsor has met the MLR (minimum loss ratio) requirement.”⁷ CMS found that, from 2010 to 2020, Part D sponsors and their PBMs consistently received more DIR than projected in their bids by an average of 0.6 percent of gross drug costs and by as much as 3 percent of gross drug costs.

To ensure plan sponsors’ use of pharmacy DIR does not increase costs for beneficiaries and taxpayers, CMS proposes to eliminate the exception for contingent pharmacy price concessions. Beginning in 2023, the agency would adopt a new definition of “negotiated price” to include all pharmacy price concessions, including performance-based ones assessed after the point of sale. Under the proposal, CMS would require plan sponsors to reflect in the “negotiated price” the lowest possible reimbursement a network pharmacy could receive. That amount would be the basis on which enrollee cost sharing is assessed. The policy would not apply to non-pharmacy price concessions such as manufacturer rebates and discounts. Under this approach, plan sponsors could, if they chose, reward high-performing pharmacies with postsale incentive payments rather than assessing retroactive fees for poor performance.

⁶ Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2022. Medicare program; contract year 2023 policy and technical changes to the Medicare Advantage and Medicare prescription drug benefit program. Proposed rule. *Federal Register* 87, no. 8 (January 12): 1842–1960.

⁷ Centers for Medicare & Medicaid Services, 2022, op. cit., p. 1913.

Comment

The Commission shares CMS's concern that beneficiaries and the Medicare program are likely paying cost sharing that is too high. We estimate that in 2020, pharmacy DIR averaged more than \$6 per claim, up from less than \$1 per claim before 2015. As the agency notes, the current approach to pharmacy price concessions reduces plans' benefit costs and premiums while shifting some of the costs to beneficiaries and Medicare's LIS via higher cost sharing. CMS estimates that the proposal would lower Part D enrollees' out-of-pocket (OOP) costs by an estimated \$21.3 billion (2 percent) over ten years.⁸

We support this proposal as a way to ensure that both beneficiaries and the Medicare program (which pays for LIS cost sharing) benefit from the lower prices negotiated by plan sponsors and their PBMs in the form of pharmacy DIR. At the same time, given the wide variation and lack of transparency in performance metrics used by sponsors, it is unclear whether current contract terms for pharmacy DIR achieve the purported goal of improving quality of services among their network pharmacies. To encourage network pharmacies to provide high-quality services, we strongly encourage CMS to complement this proposal by facilitating the development and use of standard measures of pharmacy performance.

We note that there are tradeoffs to adopting this proposal. Most notably, any policy that shifts some or all DIR to lower point-of-sale prices rather than premiums would increase beneficiary premiums and Medicare's costs through its effects on premium subsidies and manufacturer discounts. Under the proposal, CMS estimates that Medicare's Part D program spending would increase by \$40 billion (3 percent) over ten years.⁹ (Enrollee premiums would rise by \$11.8 billion (5 percent), or about \$20 per member per year.)

In weighing the tradeoffs between higher cost sharing versus lower plan premiums, we note that despite the aggressive growth in prices of brand-name drugs and biologics, premiums for basic Part D benefits have remained low, staying within a few dollars of \$30 per month since 2010. Meanwhile, individuals who need expensive medicines often face high cost sharing.¹⁰ Financing benefits through higher cost sharing disproportionately affects those who take medications, undermining the primary purpose of insurance to limit financial risk. This proposal would help guard against further erosion of the insurance protection of Part D's benefit.

However, we believe it is also important to address manufacturer rebates, which account for the vast majority of DIR. Because Part D's benefit parameters are calculated based on spending using negotiated prices at the pharmacy, the growing gap between gross and net-of-DIR spending erodes

⁸ The \$21.3 billion reflects the net effects of lower cost sharing paid by Part D enrollees (\$33.1 billion) and higher enrollee premiums (\$11.8 billion) over the 2023 to 2032 period. (Centers for Medicare & Medicaid Services, 2022, op. cit.).

⁹ Medicare's higher spending would result from higher Part D premium subsidies (\$76.7 billion in direct subsidies and \$3.5 billion in low-income premium subsidies over the 2023–2032 period) offset somewhat by lower spending on low-income cost sharing subsidies (\$24.4 billion) and reinsurance (\$15.8 billion). Manufacturers of brand-name drugs would save about \$14.6 billion over ten years through lower coverage-gap discounts.

¹⁰ Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC. (Forthcoming.)

the value of Part D's benefit by increasing the share of drug costs paid by beneficiaries via cost sharing. While CMS is prohibited from taking any policy actions to address similar issues created by manufacturer rebates prior to January 1, 2026, we encourage the agency to consider policies that would allocate the financial benefits of DIR more equitably among beneficiaries, plan sponsors, and Medicare.¹¹ In the near term, CMS could consider:

- Changes to the formula the agency uses to distribute DIR more equitably between plan liability for basic benefit costs and Medicare's reinsurance.
- Requiring sponsors to reflect some or all of the DIR in cost-sharing amounts in their Part D bids.¹²
- Imposing a penalty on plans that systematically underestimate DIR in their Part D bids.

Ultimately, however, the Commission believes that Part D's benefit design and financing need to be restructured to ensure sponsors face incentives that align with the interests of the program and its beneficiaries. In 2020, the Commission recommended changes to Part D that would phase in a reduction of Medicare's reinsurance from 80 percent to 20 percent while simultaneously increasing capitated payments to plans, among other changes.¹³ Those recommendations could better align financial incentives for plan sponsors to include lower-priced drugs on their formularies. Adding an annual OOP cap would provide complete financial protection to all beneficiaries.

Conclusion

MedPAC appreciates your consideration of these issues. The Commission values the ongoing collaboration between CMS and MedPAC staff on Medicare policy, and we look forward to continuing this relationship. If you have any questions regarding our comments, please do not hesitate to contact James E. Mathews, MedPAC's Executive Director, at 202-220-3700.

Sincerely,



Michael Chernew, Ph.D.
Chair

MC/aj/er/lr/rs/ss

¹¹ Section 90006 of the Infrastructure Investment and Jobs Act (Pub. L. 117-58, November 15, 2021) prohibits the Secretary from implementing, administering, or enforcing the provisions of the "rebate rule" prior to January 1, 2026.

¹² Medicare Payment Advisory Commission. 2018. Comment letter on CMS's notice of proposed rulemaking entitled "Medicare program; 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." January 3.

¹³ Medicare Payment Advisory Commission. 2020. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.