September 20, 2023

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Via Email: PartDPaymentPolicy@cms.hhs.gov

Re: Comments on Maximum Monthly Cap on Cost-Sharing Payments Under Prescription Drug Plans: Draft Part One Guidance on Select Topics, Implementation of Section 1860D-2 of the Social Security Act for 2025, and Solicitation of Comments

To Whom It May Concern,

On behalf of the Medicare Committee of the American Academy of Actuaries[1] (the committee), we appreciate the opportunity to provide comments on the draft part one guidance for the *Maximum Monthly Cap on Cost-Sharing Payments Program*.[2]

The committee's comments cover four areas of the Medicare Prescription Payment Plan (MPPP) for Centers for Medicare & Medicaid Services (CMS) consideration, discussed further below.

1. Simplification of the monthly payment formula
2. Consideration of various options for enrollment outreach
3. Creation of a centralized tool for beneficiaries
4. Analysis of the potential downstream impact on health plan operations and incentives

Simplification of the monthly payment formula

While the formula for calculating monthly participant payments is relatively simple, understanding the resulting values can be difficult. Plans and pharmacists may be challenged to explain to participants how their payment amount is set, and participants may be confused by the sometimes significant changes in payment amounts from one month to the next.

An alternate approach might treat each month as a distinct "no-interest loan," in which the payment is always calculated as [Out-of-Pocket (OOP) Costs] / [# of months remaining in year]. Under this approach, the payment amount for any given loan would never change, but the number of loans provided could increase if the participant has additional OOP costs in future months (resulting in a

[1] The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
[2] https://www.cms.gov/files/document/medicare-prescription-payment-plan-part-1-guidance.pdf

greater total payment owed). Under the current approach, payments are often highest in the first month, lower in the second month, and gradually increase afterward. Under this alternate approach, payments would be the same in all months for a single loan, and total payments would stay the same or gradually increase in subsequent months until the Maximum Out-of-Pocket (MOOP) is met. A calculation like this may make it easier for participants to understand what they owe for each month (leading to better compliance), ease the burden on pharmacists, and result in fewer billing errors.

Consideration of various options for enrollment outreach

The methodology for identifying enrollees who are "likely to benefit" (section 60.2) has several limitations. Because it relies on 2023 expenditures to identify people likely to benefit in 2025, this method will likely miss newly diagnosed patients who will begin treatment in 2024 or 2025. These patients are more likely to face high OOP costs for the first time, and, as a result, they may be important to flag as "likely to benefit." While the targeted Part D enrollee notification at point-of-service (POS) initiative is likely to alleviate this limitation, it may benefit from an accompanied enrollment option at the POS (possibly via the website application described in section 70.3.1).

Additionally, given how different the benefit design will be in 2025 due to the *Inflation Reduction Act* (IRA), historical OOP costs may not predict future OOP costs well. The proposed methodology will likely overstate the number of people likely to benefit if based on 2023 OOP costs due to the lack of MOOP in 2023. CMS could consider re-adjudicating claims to 2025 defined standard benefits.

A relatively simple improvement to CMS' proposed methodology could include identifying and publishing the top 20 drugs most likely to trigger OOP costs in excess of the monthly cap based on historical data, providing enrollees with additional information for decision-making.

Creation of a centralized tool for beneficiaries

As discussed above, it may be difficult for a participant to understand and plan for the amounts owed each month, which makes it critical to have accurate and easy-to-understand tools for enrollees to decide whether the program is right for them. An interactive online tool in which enrollees can input their expected claims by month could be beneficial. Rather than duplicating resources by having each plan sponsor develop its own tool—which could result in inconsistent beneficiary experiences—we suggest that CMS develop a tool used by all plans and to which pharmacists could direct enrollees. One possibility would be to build the tool or provide a link directly within Medicare Plan Finder (MPF) on medicare.gov. To the extent MPF already has functionality for enrollees to input their expected drug claims and calculate their estimated OOP costs, it would be a natural extension to use the same data to also show what monthly participant payments would be under MPPP. This could encourage more proactive decisions by enrollees to opt in to MPPP, which will help prevent any delays in treatment or operational complications associated with real-time enrollment.

With regard to real-time enrollment, we note that the guidance suggests plan sponsors develop a mobile or web-based application. However, as noted above, this may be less efficient and more prone to inconsistent beneficiary experiences and/or calculation errors than if CMS coordinated the development of a single application to be used by all plan sponsors.

We note the following additional considerations which would help make a decision tool successful:

- While many enrollees may appreciate the ability to input their own costs, such as through MPF as discussed above, others may benefit from a few default examples, such as a $500 OOP cost and a $2,000 OOP cost, in January versus June, for example, to illustrate what could be typical payment amounts or the pattern of change in payments throughout the year. This could be illustrated in a flyer sent to enrollees and available at the pharmacy counter.
- For user-input costs, the tool could allow for input of a drug name and automatically look up the expected OOP costs, as many enrollees may not know the cost of their drug or understand what their OOP costs will be as they move through the benefit phases.
- Similarly, a tool could account for prior OOP costs to inform enrollees that participation may not be as beneficial if they are already near their MOOP for the year.
- To the extent CMS encourages plans to provide information on the Low Income Subsidy (LIS) program, the tool could also directly compare OOP costs under the LIS program to demonstrate the incremental value of the program and include a link to information on LIS eligibility and the application process.
- It will be important for enrollees to understand how MOOP accumulation is affected by the program, given accumulation will be based on costs incurred rather than actual monthly payments under MPPP.

Analysis of the potential downstream impact on health plan operations and incentives

The following are some additional considerations as CMS implements this important new program:

- ***Medicare Stars Rating Impact*—**We encourage CMS to monitor any Stars impacts from implementing this program. Members could be confused about certain elements of the program (e.g., varying payment amounts over time, or conflicting information from member tools), which could drive a negative perception of the program and member complaints.
- ***Adherence*—**We encourage CMS to continue to explore ways to encourage higher levels of adherence for stand-alone Prescription Drug Plan (PDP) members. While Medicare Advantage plans benefit financially from adherence through the Stars bonus program and potential medical cost offsets, PDPs do not benefit financially and incur additional prescription costs. This program could further increase adherence, a desired outcome, but we recommend aligning PDP incentives with that goal.
- ***Bad Debt*—**There will be higher levels of uncertainty (particularly in the first year) with regard to projected bad debt levels. Bad debt is likely to impact plan financials and may cause premiums to increase. We encourage CMS tracking of the bad debt filed in bids before and after implementation to monitor if there is any material impact from the program's implementation. Bad debt impacts could be larger for plans with higher morbidity populations, such as special needs plans.
- ***Low-Income Membership*—**Section 70.2 of the draft part one guidance states the importance of informing individuals interested in the Payment Plan of potential eligibility in the LIS program. This section also states that the draft part two guidance will provide "additional requirements" about "Part D sponsor responsibilities related to Part D enrollees participating in the LIS program." Other interested parties have estimated that 2 million to 3 million LIS-eligibles have not enrolled.[3] With potentially millions of enrollees being affected, we would ask that CMS

[3] "Take-Up Rates in Medicare Savings Programs and Extra Help"; National Council on Aging; Sept. 9, 2022.

consider how such requirements might affect Part D LIS/non-LIS market segmentation, such as described in recent MedPAC work or other Part D plan dynamics.[4] In addition, we would ask for clarification on whether or how CMS intends to measure or reward/penalize a plan's enrollment in the Payment Plan by LIS-eligibles. Finally, we recommend that CMS ensures the payment plan is beneficial to a given LIS member, as examples like B7 may be worse for the member than not smoothing.

- ***POS Election*—**Even if unachievable for the 2025 plan year, we believe the opportunity for participants to elect into the program at the POS could be valuable for increasing program elections. We encourage thoughtful consideration of implementing POS election in the near future and consideration of ways to engage other stakeholders (e.g., retail pharmacies) to assist. Historically, providers have struggled with having accurate and reliable benefit plan information at the POS, which will be important for this program.

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The committee appreciates the opportunity to provide comments on the draft part one guidance on the *Maximum Monthly Cap on Cost-Sharing Payments Program* and welcomes the opportunity to speak with you in more detail and answer any questions you have regarding these comments. If you have any questions or would like to discuss this further, please contact Matthew Williams, the American Academy of Actuaries' senior health policy analyst, at williams@actuary.org.

Sincerely,

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[4] "Segmentation in the stand-alone Part D plan market"; *MedPAC Report to Congress*, chapter 7; June 2022.