MEDPAC Medicare Payment Advisory Commission

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October 4, 2004

Mark McClellan, Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Hubert H. Humphrey Building
Room 443-G
200 Independence Avenue, SW
Washington, D.C. 20201

Re: File Code CMS-4068-P

Dear Dr. McClellan:

The Medicare Payment Advisory Commission (MedPAC) is pleased to submit these comments on CMS's proposed rule entitled *Medicare Program; Medicare Prescription Drug Benefit*. We appreciate that your staff has an enormous task in implementing the provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), particularly given the agency's competing demands.

MedPAC's comments aim to help CMS strike a balance among policy goals that sometimes compete with one other. Part D will only provide the outpatient prescription drug benefit that Medicare beneficiaries need if CMS is able to encourage private plans to enter the market and offer competitive benefits at affordable premiums. At the same time, CMS must ensure that Part D enrollees have access to the drug therapies they need. We appreciate the complexity of CMS's task in striking this balance, and MedPAC intends for its comments to help CMS in that mission.

Many important details relating to CMS's implementation of Part D fall outside of these proposed rules yet are critically important for the decision making of beneficiaries and private plans. Examples include specification of the boundaries of regions in which Part D plans will operate, publication of risk adjustors that will apply to drug plan payments, and CMS guidance on formulary structure and operations, on the process for grievance and appeals, on evaluating actuarial equivalence, and on the process for obtaining employer or Medicare Advantage plan waivers. We look forward to timely decisions about these and other details, and we may provide further comments once they become available.

As you requested, our comments are organized and identified by the corresponding sections in the proposed rule.

Background

Eligibility and Enrollment (B)

Limiting direct marketing to beneficiaries

The MMA provides that prescription drug plans (PDPs) are able to market directly to beneficiaries to encourage enrollment and that CMS provides contact information to PDP sponsors to facilitate efficient marketing. You ask whether you should limit this practice, for example, by allowing beneficiaries to choose not to be contacted, restricting contacts to certain times of the year or to written materials instead of telephone contacts.

Allowing PDPs to contact Medicare beneficiaries directly has the potential to lower the marketing costs of Prescription Drug Plans (PDP) which, in turn, may reduce beneficiaries' premiums for Part D coverage. However, such efficiencies should be balanced with other program goals, such as protecting beneficiaries' privacy and reducing beneficiary confusion about the new program. Allowing beneficiaries to choose not to be contacted and restricting contacts to before and during the annual open enrollment period would seem to be reasonable limits consistent with these program goals.

Marketing services other than PDP services to beneficiaries

CMS states in the preamble that it is interested in the possibility of allowing PDP sponsors to market other products including financial services to beneficiaries as well.

We appreciate CMS's interest in providing additional incentives to entities to participate as PDPs, thereby spurring competition and offering beneficiaries choices among plans. With the introduction of the drug benefit under Part D, beneficiaries will have to learn about a new benefit and make choices among a number of plans with different kinds of cost-sharing structures, formularies, and pharmacy networks. Adding the marketing of other products by PDP sponsors would only add to the potential confusion and would also add to CMS's burden in reviewing marketing materials. We strongly oppose this option at this time but believe the policy could be reviewed at a later date.

Timing of the auto-enrollment period for dual eligible beneficiaries in the first year

The initial enrollment period extends from November 15, 2005, through May 31, 2006. The auto-enrollment processes for full dual eligible beneficiaries who do not enroll in some plan starts after this period. Medicaid coverage for full duals ends on December 31, 2005, leaving a potential five-month gap in coverage for the poorest beneficiaries.

There are several possible solutions to this problem: The choice should rest on which solution is the least administratively burdensome for states and the federal government and best ensures continuous coverage for this vulnerable population. Perhaps the simplest solution would be to start the auto-enrollment process when the initial enrollment period begins. Although this approach would have the potential disadvantage of enrolling beneficiaries in plans they would not have chosen for themselves, it would ensure continuous coverage for all dual eligibles. To preserve choice, these beneficiaries could then have the option of changing plans once before the end of the initial enrollment period. We anticipate that few beneficiaries would change plans. A second solution could be to begin and end the initial enrollment period earlier for dual eligibles, but this would be administratively complex for both CMS and the states.

Disenrollment of beneficiaries by PDPs

At the plan's discretion, PDPs may disenroll a beneficiary involuntarily if he or she does not pay premiums or is disruptive. In other circumstances, PDPs are *required* to disenroll beneficiaries, such as when they withhold information to PDPs about third-party coverage. There is no special election period that allows involuntarily disenrolled beneficiaries to enroll in another PDP.

As CMS points out, in the Medicare Advantage context, the beneficiary who is dropped from a plan for nonpayment of premiums or other bad behavior defaults to fee-for-service Medicare coverage. However, for Part D drug coverage, there is no default. CMS describes its intentions to provide re-enrollment guidelines, and proposes regulations that require plans to give a proper notice and due process, review the case, and document their efforts to resolve issues leading to disenrollment. Because of the lack of default Part D coverage, CMS should also consider including a warning to beneficiaries enrolling in plans about involuntary disenrollment and its consequences.

Under the Medicare Advantage program (which forms the basis for many enrollment and disenrollment provisions in the statute and regulations for PDPs), a beneficiary who is out of a PDP service area for more than six months must be involuntarily disenrolled. CMS asks for comments on whether this regulation should also apply to PDPs.

Because the scope of benefits in a PDP is much more limited than the Medicare Advantage program, and enrollees may be able to get prescription drugs through mail order or through nationwide retail pharmacy networks, MedPAC agrees with CMS that automatic disenrollment for people out of the service area for more than six months is not necessary. Instead, PDPs should be allowed to structure pharmacy excess rules specifically for beneficiaries who are out of the service area for extended periods of time. Indeed, in subpart C of the regulation text, CMS considers pharmacy excess rules (such as mail order) that PDPs may impose on beneficiary members who have extended out-of-network travel.

Educating beneficiaries

The preamble reviews how Medicare provides comparative information to beneficiaries on www.medicare.gov and through the 1-800-Medicare line but provides little guidance on the range of activities that will be necessary for beneficiary education. Research consistently has shown that web-based resources are not sufficient to explain to some beneficiaries the complex choices they will face. Many beneficiaries will require individual counseling. State SHIPs and other volunteer groups must be adequately prepared to enable them to perform this task.

It would be useful to devote some resources to developing educational materials for pharmacists and physicians on the Part D drug benefit. CMS might provide the same kinds of educational materials that it has developed to help SHIPs advise beneficiaries about their choices. MedPAC's research on drug benefit implementation issues, included in our June 2004 Report to Congress, shows that pharmacists and physicians, as trusted intermediaries, are often in the position of explaining plan benefits and benefit changes to their patients. Yet, they rarely have sufficient information available to do so quickly, accurately, and efficiently. We found that despite considerable efforts by employers to inform their employees about changes in their drug benefit plans, many plan recipients first became aware that their plan had changed when they were in a physician's office or attempted to fill a prescription at a pharmacy.

While plans must take several measures to educate participating pharmacists and physicians affected by formulary changes, Medicare should also educate them on beneficiary needs and Medicare requirements under the new drug benefit. Recent studies indicate that many beneficiaries, particularly those receiving drug benefits from Medicaid, are unaware that they will be affected by the Medicare drug benefit. Knowledgeable pharmacists and physicians may often be required to explain benefit options to many members of this population.

Benefits and Beneficiary Protections (C)

Formulary regulations

Plans participating in the Medicare drug benefit may develop and use formularies to manage the cost and utilization of prescription drugs. The MMA charged the United States Pharmacopeia (USP) with developing a model classification system. Plans have the flexibility to use USP's model, or to develop their own classification system. In either case, plans must list at least two drugs in each therapeutic category and class, if available. If a plan uses USP's model, CMS cannot find its classification system to violate regulations against discrimination of beneficiaries. However, CMS may continue to scrutinize other components of the plan's formulary and utilization management programs (e.g., specific drugs listed, prior authorization requirements) for such discrimination. If a plan decides *not* to use USP's final model, it will need to show that its departure from the model is not designed to discourage certain beneficiaries from enrolling.

In MedPAC's June 2004 Report to Congress, we examined formulary implementation issues for the upcoming Medicare drug benefit. Specifically, we outlined competing demands on plans'

classification systems to be broad enough to enable plans to manage drug costs, but specific enough to ensure adequate drug coverage for beneficiaries.

The MMA affords plans the flexibility to develop and use their own tools to manage drug costs, within limits. For the success of the new drug benefit, plans will need to keep premiums relatively low, which requires them to have the ability to rely on many of the utilization management tools that are available in current practice. And ultimately, whether formularies are broad or narrow, CMS will still need to ensure that plans have effective exceptions processes so that beneficiaries can get the drugs that are medically necessary for their specific conditions.

One issue we see pertaining to CMS's proposed formulary regulations is the lack of clarity on the cost-sharing status of drugs in each therapeutic category. Although the regulations state that plans must list at least two drugs (if available) per therapeutic category and class, they do not explicitly address cost-sharing levels of the required drugs. That is, will one or more of these drugs need to be at the preferred level, or could plans provide only nominal coverage in an entire category? Could plans vary cost-sharing structures between categories? If so, CMS will need to closely scrutinize plans' cost-sharing structures, *per category and per drug*, to rule out beneficiary discrimination. To do so, CMS could estimate plan cost sharing (as a percent of total drug spending) for selected groups of beneficiaries, and compare those to average ranges. In any case, CMS will need to review all PDP bids to assess whether formularies and cost-sharing structures are in keeping with those used in current practice by most health plans.

Pharmacy & Therapeutics (P&T) committee role

By statute, a plan's formulary must be "developed and reviewed" by a P&T committee. CMS proposes strengthening the committee's role to make its decisions binding on the plan. CMS also expects that P&T committees will be involved in designing formulary tiers and clinical programs implemented to encourage the use of preferred drugs (for example, prior authorization, step therapy, and generics programs).

MedPAC is concerned that CMS's proposal to make P&T committee decisions binding on the plan extends the role of P&T committees beyond current practice. Our research on drug benefit implementation issues, included in our June 2004 Report to Congress, shows that a plan's P&T committee typically serves as an advisory body to the plan. While plans usually accept their P&T committee's recommendations, plans have the final say on formulary decisions. Also, we found that P&T committees are often tasked with recommending preferred drugs, but do not establish the actual cost-sharing structure. This component of benefit design is usually under the plan's purview. Our research also showed that P&T committees may recommend which drugs should require other utilization procedures, such as prior authorization to improve patient safety. However, as in formulary decisions, plans ultimately oversee the implementation of such utilization management programs.

P&T committee independence

Among other membership conditions, P&T committees must include one practicing physician and one practicing pharmacist who are "independent and free of conflict with respect to the sponsor and plan" – meaning that they have no stake, financial or otherwise, in formulary decisions. CMS proposes strengthening the independence requirement in two ways: first, by increasing the number of independent members, and second, by adding pharmaceutical manufacturers to the list of entities from which independent members must be free of conflict.

MedPAC strongly supports CMS's overall desire to increase the independence of P&T committee membership. Defining the number of members who are independent may be somewhat arbitrary, however. MedPAC agrees with CMS that those members who are designated as "independent" should be free of conflict from drug manufacturers (in addition to plans and sponsors). CMS should, at a minimum, require plans to establish a disclosure and recusal process for all P&T committee members who have any type of arrangement or relationship with drug manufacturers. Under this process, P&T members would recuse themselves from decisions that involve specified therapeutic categories or classes that may pose a conflict of interest for them. Our research found that this course of action was common among plan P&T committees.

Out-of-network pharmacy access

Under the MMA, plans must guarantee enrollee access to covered drugs from out-of-network pharmacies when they cannot reasonably be expected to get their drugs from network pharmacies. CMS proposes four conditions that may grant enrollees coverage at out-of-network pharmacies. CMS also proposes that plans can limit out-of-network access to encourage in-network use, including limiting amounts of covered drugs dispensed, requiring use of mail-order for extended time out of service area, and requiring plan notification for out-of-network fills.

CMS's proposals for granting enrollees coverage at out-of-network pharmacies are reasonable, but CMS needs to ensure that plan rules meant to encourage in-network use are not so burdensome and complex that they obstruct beneficiary access to needed medications in a timely manner. In particular, the prior notification requirement may be problematic for many beneficiaries. Nursing home patients in a facility without a network pharmacy, for example, cannot be expected to notify their plan of each type of drug they intend to use in the nursing home. Also, if plans require prior notification for out-of-network fills, plans should be required to provide a customer service line 24 hours a day, seven days a week, to answer the calls.

Rural pharmacy access

The MMA requires plans to provide enrollees with at least the same access to retail pharmacies as is provided by the Department of Defense's TRICARE program. In rural areas, therefore, plans must ensure that at least 70 percent of Medicare beneficiaries have access to a participating

retail pharmacy within 15 miles. CMS is proposing that PDPs serving more than one region meet excess requirements within each region.

Because CMS has not yet defined the plan regions, it is difficult to evaluate the impact of TRICARE standards on access to pharmacies. If the regions are relatively small, beneficiaries are less likely to encounter pharmacy access problems, but if the regions are large, multi-state areas, access may be more problematic, especially in rural areas. In these cases, up to 30 percent of Medicare beneficiaries living in large portions of rural state may not have access to a participating pharmacy within 15 miles of their home. We note that these beneficiaries will be able to receive some drugs through a mail-order option and access a limited supply of medication at out-of-network pharmacies in the event of an emergency. In either case, we recommend that CMS monitor network adequacy in its review of plan bids to ensure that certain geographic areas are not subject to systematic discrimination.

Cost Control and Quality Improvement Requirements for Prescription Drug Benefit Plans (D)

E-prescribing

The MMA includes several provisions to encourage the use of e-prescribing. MA plans and PDPs may pay physicians differentially based on their use of e-prescribing as long as these arrangements are in compliance with A Stark self-referral and antitrust statutes. E-prescribing is one important step toward broader use of information technology and has been shown to lead to reductions in medication errors. MedPAC strongly supports moving toward greater use of electronic health information systems.

The MMA directs HHS to develop a safe harbor from the anti-kickback statute and an exception from the Stark self-referral rules. The Secretary should proceed expeditiously to issue such guidance.

Submission of Bids and Monthly Beneficiary Premiums (F)

Tradeoffs associated with the late enrollment penalty

Part D's late enrollment penalty would be the greater of two amounts: one determined by CMS to be actuarially fair, or 1 percent of the base beneficiary premium for each uncovered month. That penalty would apply every month for as long as the beneficiary was enrolled in Part D. CMS expects to use the 1 percent per month approach until it has collected enough data to do an actuarial estimate. For 2006, this would be about $0.36 per month—so someone who waited a year to enroll would pay an extra 12*$0.36=$4.32 per month forever. CMS suggests this approach because it does not yet have enough data to know what additional costs the program would incur if beneficiaries delay enrollment.

MedPAC urges CMS to collect data as quickly as possible to calculate a penalty amount that fairly reflects any higher costs associated with beneficiaries who delay their enrollment. Ideally, CMS would begin using this actuarially fair penalty after, say, one year of the program. Beneficiaries on long-term drug therapies for managing chronic conditions can often predict their prescription drug spending quite well, making this market especially susceptible to adverse selection. The role of the late enrollment penalty is to encourage high levels of enrollment in Part D, since otherwise plans should expect that beneficiaries with the greatest use of prescription drugs would be among the earliest to enroll. Indeed, plans may not choose to enter the market to deliver Part D benefits at all if their only likely enrollees are those with the highest drug expenditures. Nor should all enrollees subsidize the decision of others to delay their enrollment. The penalty should be as high as is fair to encourage enrollment and thereby promote participation by plans, but no higher so as to avoid unduly penalizing lower income beneficiaries, since some or all of those penalties will not be covered by low-income subsidies.

CMS'S role in reviewing PDP price information

The MMA gives CMS authority to negotiate bids and benefits similar to that of the Office of Personnel Management (OPM) for administering the Federal Employees Health Benefits Program (FEHBP). CMS interprets this to mean authority to determine whether bids reasonably reflect the cost of benefits provided, whether bids and trends in premiums are in keeping with those charged in other insurance contexts, whether the level of benefits reflects reasonable minimum standards for health plans, whether administrative costs are reasonable, and whether plans are taking reasonable steps to control costs and otherwise manage the plan well.

CMS's position is appropriate: it would not set the price for any individual drug or even an average discount across a group of drugs. However, the agency would look for justification from plans if aggregate price levels for groups of drugs were higher than prices observed among peer plans. This is due diligence and a reasonable course of action short of direct price regulation. However, CMS must allocate sufficient levels of staffing to ensure that it can credibly accomplish this oversight role. As one basis of comparison, CMS could look to OPM's staffing levels for administering FEHBP.

Coordination Under Part D Plans with Other Prescription Drug Coverage (J)

Tracking true out-of-pocket costs

Part D's true out-of-pocket provision holds that only the enrollee's own spending, or that of a close relative on behalf of the enrollee, qualifies for purposes of satisfying the Part D benefit's out-of-pocket threshold. In other words, coverage that wraps around the Part D benefit—such as through retiree drug benefits—would not count when plan sponsors calculate whether an enrollee had reached $3,600 in out-of-pocket spending during 2006. This provision was included as a mechanism to restrain Medicare's program payments for Part D benefits. But its effectiveness can only be as successful as CMS's ability to monitor whether Part D enrollees have supplemental drug coverage.

CMS invites comments on options for facilitating the exchange of data needed to track true out-of-pocket spending. Managing this information flow is an especially challenging task because of the need for data on a real-time basis at the point of sale in order to accurately calculate enrollee cost sharing. CMS proposes three options: making PDPs and MA-PDs solely responsible for tracking true out-of-pocket costs, awarding a contract to a facilitator that would become the single point of contact between primary and secondary payers and pharmacies, or establishing its own query system that would provide billing information to pharmacies about the order of payers. Although the latter two options pose technical challenges for CMS, MedPAC does not support the first option. PDPs and MA-PDs who contract with third-party payers may not enforce this provision too stringently, since it reduces the likelihood of receiving federal reinsurance payments. CMS should also explore other ways to monitor reporting of third-party coverage.

Employer/union group waiver authority

One option available to employers or unions is to contract with a PDP sponsor or MA-PD organizations and request permission to waive requirements under Part D that hinder the design or offering of plans for their retirees. Such waivers allow drug plans to furnish employer/union groups with Part D benefits and establish separate premiums for them, similar to authority used by MA organizations under Part C. CMS would make separate payments to such plans. A goal of these waivers is to facilitate efficient administration and integration of enhanced Part D benefits with other retiree health benefits.

While we understand the important role that waivers can play in encouraging employers and union groups to continue providing drug benefits to their retirees, we also hope that CMS will use its authority judiciously. In particular, it may be difficult to distinguish between bid costs for standard versus supplemental benefits, thereby complicating the monitoring and enforcement of the MMA's true out-of-pocket provision.

Grievance, Coverage, Reconsideration, and Appeals (M)

Non-formulary and non-preferred exceptions process

Plans must have an exception process for enrollees to request coverage for non-formulary drugs and for obtaining preferred cost-sharing status for non-preferred drugs. To obtain such exceptions, the prescribing physician must determine that a formulary or preferred drug would not be as effective for the enrollee, would have adverse effects, or both. Plans may determine the standards for documenting and concluding that an exception is necessary. Such standards may include step therapy, which requires that the enrollee first tried the preferred drug.

In reviewing plan proposals, CMS must ensure that plans have effective exceptions processes so that beneficiaries can access medically necessary drugs for their specific conditions.

As a drug utilization management tool, step therapy can be appropriate for some drugs and some populations, but risky for others. As we discussed earlier, MedPAC believes that P&T committees should provide guidance and recommendations to plans with regard to policies for specific drugs for given therapeutic indications. In doing so, P&T committees should take into account clinical effectiveness, patient safety, and cost considerations. Also, CMS has the responsibility to assess plans' drug utilization management tools, including step therapy, to ensure that they are not designed to discourage enrollment by certain beneficiaries, such as those with high expected drug costs.

While the MMA requires that beneficiaries themselves initiate the exceptions process, CMS proposes to also allow physicians to initiate the exceptions process. However, CMS clarifies that physicians could only initiate the process for their individual patients, not for their patients as a group. MedPAC agrees that physicians should be able to initiate the exceptions process for their individual patients because it could increase beneficiary access to needed medications.

Grievances and appeals procedures

Plans must have grievances and appeals procedures in place for beneficiaries to obtain coverage for medically necessary drugs. The regulations proposed for Part D generally follow the timetables and procedures outlined in the Medicare Advantage appeals process. However, denied appeals and requests for reconsideration will not be forwarded automatically to an independent review agency, as they are for A/B benefits in MA plans. Rather, enrollees must request such a review. Under certain circumstances, physicians may appeal on their individual patients' behalf. Plans are not required to cover drugs that are pending appeal.

In general, the proposed regulations on grievances and appeals procedures are not prescriptive and allow plans to establish the criteria and the standards for approving or denying appeals. Further clarification on the standards by which Part D plans and external appeal's reviewers can deny appeals would be helpful. Also, MedPAC believes that physicians should be allowed to appeal on behalf of their individual patients throughout the entire exceptions and appeals process. Considering that appeals would not be automatic, allowing increased physician involvement may be helpful for beneficiaries who require access to non-formulary drugs, but who have difficulty navigating through the multi-step appeals process themselves. Finally, CMS could consider requiring plans to cover a beneficiary's drug that is pending an appeal. However, in doing so, CMS should include maximum time limits on the coverage, such as a defined, short-term emergency supply.

Intermediate Sanctions (O)

For poor plan performance, CMS is inclined not to close enrollment and to use civil monetary penalties instead to maximize choice for beneficiaries, particularly in the case when there are only two PDPs in a region. This is different treatment than that of MA plans, where suspending enrollment has been used.

CMS should not rule out closing enrollment if plans are harming or misleading beneficiaries. If engaged in activities that harm beneficiaries, it is not a good choice and enrollment should be suspended. Civil monetary penalties of no more than $100,000 may be insufficient in such a case to penalize poor behavior.

Guaranteeing Access to A Choice of Coverage (Qualifying Plans and Fallback Plans) (Q)

Review of drug prices for fallback plans

In evaluating bids by fallback plans, CMS intends to negotiate price-related performance targets. Options include tying performance payments to the average discounts plans are able to negotiate with manufacturers including rebates. CMS proposes using a benchmark to determine if a drug plan is negotiating reasonable prices from manufacturers and asks for comments on whether this violates the noninterference provisions of the law.

We support CMS's use of a benchmark in its negotiations and believe it represents due diligence on the part of the agency to ensure that beneficiaries and the Medicare program are not penalized with high prices in areas in which there are no choices among plans. CMS suggests that the benchmark could be based on a number of sources including the average wholesale price (AWP), the average sales price, or the prior year's negotiated price. We agree with CMS that it would be best not to use a benchmark based on AWP. Use of AWP in determining payments for drugs under Medicare Part B resulted in inaccurate payments, unrelated to acquisition costs by purchasers. We support the use of a benchmark based upon actual transaction prices.

Availability of fallback plans

Many elements of the regulation related to fallback plans appear designed to make the fallback an unattractive business proposition for firms. For example, CMS would establish a separate bidding process for fallback plans. Plans would submit bids in the first half of 2005 to offer fallback plans in one or more regions in 2006. Any plan submitting a bid as a fallback plan could not submit a bid as a risk plan in any area of the country. Awards would be made but plans would only be used if necessary and plans awarded fallback contracts could not offer risk plans for at least three years. Further, contracts could be amended at any time to reflect the exact regions or counties to be included in the fallback service area.

While the Commission fully appreciates the goal of encouraging plans to take risk so as to provide incentive for controlling Part D spending, the goal of providing all beneficiaries with access to drug coverage also is important. These fallback regulations may be so burdensome that no plan applies. CMS may wish to consider relaxing some of its requirements in the event that neither fallback nor risk-taking PDPs bid to cover an area.

Payments to Sponsors of Retiree Prescription Drug Plans (R)

Valuing employer subsidies

Employers with drug coverage at least as generous as that offered under Part D can receive subsidy payments if they continue to provide primary coverage for a Part D-eligible retiree. CMS is considering several tests of actuarial equivalence. The "single prong" approach is that total/gross value of the employer's benefit package must at least equal that of the standard Part D benefit, without regard to who pays the premium. Another option is to combine the first with a provision that would limit the subsidy to the amount paid by the sponsor. A third option would use "two prongs": gross benefit payouts would have to be at least as great as those for Part D, plus an additional test on net benefits—the value of benefits net of enrollee premiums.

MedPAC supports either of the approaches that would take an employer's subsidy of the premium into account. Calculating actuarial equivalence only on the benefits and not the subsidy could lead to windfall payments to employers. For example, in the most extreme case, an employer might offer a benefit that met the requirements for actuarial equivalence under the first test and charge a beneficiary the entire premium. In this case, the employer would receive a payment but incur no benefit costs. While we understand the goal of maintaining employer- or union-sponsored retiree drug coverage, in order to administer the Medicare program's resources responsibly, it is incumbent upon CMS to prevent windfall payments.

MedPAC appreciates this opportunity to comment on these proposed regulations. The Commission values the willingness of CMS staff to provide relevant data and to consult with us concerning technical policy issues.

If you have any questions, or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director at (202) 220-3700.

Sincerely,

Glenn M. Hackbarth, J.D.
Chairman