America's Health Insurance Plans

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Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development – C
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850
Attention: Bonnie L. Harkless

Re: CMS-R-262 and CMS-10142

Dear Ms. Harkless:

I am writing on behalf of America's Health Insurance Plans (AHIP) to submit comments in response to the Federal Register notice (72 FR 60852) published on October 26, 2007 by the Centers for Medicare & Medicaid Services (CMS) under the Paperwork Reduction Act of 1995 (PRA). The Federal Register notice provided an opportunity for comment on the CY 2009 Plan Benefit Package (PBP) and Formulary Submission tools for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDPs), and the Bid Pricing Tool (BPT) for MA Plans and PDPs. AHIP is the national trade association representing nearly 1,300 member companies providing health insurance coverage to more than 200 million Americans. These tools are of significant interest to AHIP's member organizations, many of which participate in the MA and Part D Prescription Drug Benefit program (Part D).

We support CMS' effort to continue to refine the PBP and Formulary Submission tools and appreciate the ongoing evolution of these tools. We also support CMS' continuing focus on refining the BPTs. We recognize that the proposed CY 2009 MA and PDP BPTs do not yet reflect changes based upon CMS' Lessons Learned initiative for the CY 2008 tools. We have not identified additional issues subsequent to that review and therefore, we are reiterating below the issues identified in our previous comments. Our comments on both the PBP and Formulary Submission, and the BPTs appear below.

COMMENTS

PLAN BENEFIT PACKAGE AND FORMULARY SUBMISSION

- **Section B-7C--Occupational Therapy--Base 1 Screen (page 62)**
  Section B-7I--Physical Therapy and Speech-Language Services--Base 1 Screen (page 81)
  The "List of Changes" document indicates that the "Do you charge the Medicare coverage limit?" box was added to these screens. Since Occupational Therapy and Physical Therapy and Speech-Language Services have benefit caps under Original Medicare, the reference in the question to the "Medicare coverage limit" is unclear. It appears that the question is intended to ask whether the plan applies the same caps for these benefits as Original Medicare. If this is correct, we recommend that CMS clarify the language accordingly.

- **Section B-9A—Outpatient Hospital—Base 1 Screen (page 91)**
  Several types of services, such as radiology, radiation therapy and lab services can be performed in more than one setting. Currently plans can list cost-sharing for these services when performed in a clinical setting. However, cost sharing for these same services may differ in the hospital outpatient setting, and it is not clear in Section B-9A how that difference should be noted. We recommend inclusion in the BID Submission manual of instructions that indicate how plans should enter into the PBP differing cost sharing for such services when performed in the hospital outpatient setting.

- **Section B-14A--Health Education and Wellness--Base 1 Screen (page 133).**
  Section B-16B--Comprehensive Dental--Base 1 Screen (page 185)
  Section B-17B--Eye Wear--Base 1 Screen (page 196)
  Section B-18A--Hearing Exams--Base 1 Screen (page 202)
  The "List of Changes" document indicates that the label "Even if you do not offer enhance [sic] benefits, you must complete this section for your Medicare Covered Benefits" was added to this screen as a clarification for data entry because these are Medicare covered benefits. It appears that label is intended to instruct that all plans must respond to the first question on this screen, "Do you offer any Mandatory or Optional Supplemental Benefits?" even if no enhanced benefits are offered. For clarity, we recommend that a note to this effect be added to the box containing the question and that the new label be eliminated.

- **Section B-14F—Colorectal Screening—Base1-5 Screens (pages 156-160)**
  There are different types of colorectal screening tests, including flexible sigmoidoscopy and colonoscopy, for which the cost sharing may differ. This section allows the PBP user to indicate whether additional screening tests are provided beyond those allowed under Medicare frequency limits, but there is no field that allows the plan sponsor to specify that cost sharing for the tests will

differ based on the type of test. Therefore, a single cost-sharing amount may be inaccurately attributed to all types of covered colorectal screening tests. We recommend that PBP users be allowed to enter distinct cost sharing amounts for each of the additional types of colorectal screening tests they cover.

- **Section B-15—Medicare Part B Prescription Drugs—Base 1 Screen (page 174)**
  For Part B drugs, the plan benefit may specify the number of days supply that will be provided in a single fill. Currently this screen does not allow PBP users to specify days supply. We recommend adding a field to allow inclusion of this feature of the benefit.

- **SECTION B–20--OUTPATIENT DRUGS (PAGES 212-17)**
  It is our understanding that last year Medicare cost plans were instructed to include in the notes section for Section B-20—Outpatient Drugs or Section B-13 Other, information regarding coverage of home infusion drugs. We recommend that CMS clarify the same instruction will apply for CY 2009.

- **Medicare Prescription Drugs Section – Alternative – Deductible Screen (page 12)**
  This screen allows the user to check either "yes," or "no" in response to the question, "Does the deductible apply to all drug types?" However, some plans with an alternative benefit may choose to apply the deductible to specialty tier, brand or generic drugs. AHIP recommends that CMS modify the PBP to permit plan sponsors to indicate that the deductible applies to one or more of the following: brand, preferred brand, generic, preferred generic, and specialty tier.

BID PRICING TOOL

MA Bid Pricing Tool Instructions

- **Cost Sharing Categories – Worksheets 1, 2, and 3.** Aggregated cost sharing categories appear in Worksheet 1—MA Base Period Experience and Projection Assumptions, and Worksheet 2—MA Projected Allowed Costs PMPM, and it is not clear how the disaggregated list in Worksheet 3—MA Projected Cost Sharing PMPM tracks to the categories in Worksheets 1 and2. For clarity and for ease and consistency of entry of cost sharing information, AHIP recommends that the disaggregated list in Worksheet 3 also be used in Worksheets 1 and 2.

Part D Bid Pricing Tool Instructions

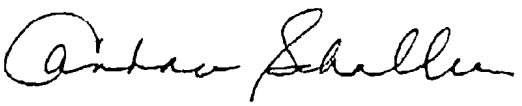
- **Use of Prescription Drug Event (PDE) Data to Complete Part D Bids.** The instructions for completing the Part D BPT indicated that plan sponsors with experience providing Part D benefits in CY 2007 were required to use PDE transactions as base period experience for CY 2009, unless the PDEs did not appropriately capture the plan's expected experience. However, plan sponsors have noted additional circumstances in which claims data may be a more appropriate basis for the PBT. For example, we understand that PDEs do not contain some of the data that is required for completion of the BPT. This is illustrated by the need for a breakout of generic and brand drug utilization which is not found in PDE data but is available in plan sponsor pharmacy claims data. AHIP recommends that CMS revise the BPT instructions to permit plan sponsors greater discretion to use either PDE or claims data.

- **Summary of Part D Benefit Structure.** The MA bid submission includes a summary of the benefit structure, but no similar summary is included in the bid submission for the Part D prescription drug benefit. To facilitate coordination of the Part D PBP and BPT, we recommend that a summary of the Part D benefit be added.

- **Establishment of Credibility Guidelines for Medicare Part D.** Under the "Special Considerations" section (page 4) of the draft CY 2009 Part D BPT instructions in the second paragraph under the heading "Base Experience", the instructions discuss the guideline for credibility for Medicare Advantage plans and indicate that credibility guidelines for the Part D benefit have not been established. AHIP recommends that CMS provide credibility guidelines for the Part D benefit for CY 2009.

We have appreciated the opportunity to comment. Please contact me if additional information would be helpful or if you have questions about the issues we have raised. I can be reached at (202) 778-3209 or cschaller@ahip.org.

Sincerely,



Candace Schaller
Senior Vice President, Federal Programs