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Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted via https://www.regulations.gov

Re: CMS—R—262 (OCN 0938-0763)

To Whom It May Concern:

Health Care Service Corporation (HCSC) appreciates the opportunity to submit comments in response to the notice under the Paperwork Reduction Act concerning the "Contract Year 2018 Plan Benefit Package (PBP) Software and Formulary Submission" published by the Centers for Medicare & Medicaid Services (CMS) in the *Federal Register* (81 FR 75406) on October 31, 2016.

HCSC is the largest customer-owned health insurance company in the United States. The company offers a wide variety of health and life insurance products and related services, through its operating divisions and subsidiaries including Blue Cross and Blue Shield of Illinois, Blue Cross and Blue Shield of Montana, Blue Cross and Blue Shield of New Mexico, Blue Cross and Blue Shield of Oklahoma, and Blue Cross and Blue Shield of Texas. HCSC serves more than 15 million members, and has established Medicare Advantage Prescription Drug (MAPD) plans and Part D Prescription Drug (Part D) stand-alone plans in all five of the HCSC states. In addition, HCSC operates a Medicare-Medicaid Plan (MMP) contract in the State of Illinois as well as Medicaid contracts in four of the HCSC states.

HCSC has the following specific comments, which we hope will be helpful as the agency works to refine the draft PBP and Formulary Submission changes for CY 2018.

COMMENTS

Plan Benefit Package (PBP)
Section D

- ***"Optional Supplemental – OON Optional" and "Optional Supplemental – OON Step-up" (pgs. 29 & 30).*** CMS is proposing to modify the PBP so that if an HMO-POS plan offers optional supplemental benefits and performs a Copy Plan (from Previous Year) of Section D, the PBP will populate and save the out-of-network (OON) Step-up fields with the values from the copied plan. HCSC supports this proposed change, which we believe will streamline data entry and promote accuracy in population of this section of the PBP since populating and saving the OON Step-up field values with the values from the copied plan will mitigate the need for manual data entry.

Formulary Submission

- ***2018 Tier Model Options.*** CMS is proposing four additional Part D formulary tier model options for CY 2018 in an effort to "help organizations to more accurately select tier models." Specifically, the agency is proposing one new three-tier structure and three new six-tier structures. We note that currently, Part D sponsors may choose to designate one formulary tier as their Specialty Tier, on which Part D drugs with sponsor negotiated prices that exceed the dollar per month threshold established annually by CMS may be placed. However, in an effort to address the increased market entry of new high-cost drugs, as well as maintain an affordable and accessible Part D program for beneficiaries, HCSC believes that CMS should permit sponsors to designate two separate specialty tiers, a preferred specialty tier with lower cost sharing and a non-preferred specialty tier.

  This approach could provide sponsors with greater leverage in negotiations with manufacturers for certain high-cost drugs, as well as encourage and increase competition among existing specialty drugs. In addition, as more biosimilar products are approved by the Food and Drug Administration (FDA), this two-specialty tier structure could encourage Part D enrollees to substitute lower-cost biosimilar products for the corresponding reference product. This could result in more affordable care for Part D enrollees and lower costs for the Part D program more broadly. We note that in their June 2016 Report to Congress[1], the Medicare Payment Advisory Commission (MedPAC) recommended that CMS revise their Part D guidance to allow for two specialty tiers, and indicated that if used appropriately, this tier structure could reduce the need for non-formulary exceptions as less cost-effective options could be placed on the non-preferred tier rather than excluded from the plan's formulary. As a result, HCSC strongly recommends that CMS revise the CY 2018 Tier model options to include an additional 6-tier structure that would allow for a preferred and non-preferred specialty tier as described above. We note that in conjunction with this recommendation, we also recommend that CMS revise the tiering exception guidance to permit plan members to obtain a 6th tier non-preferred drug at the 5th tier preferred drug cost sharing level when the 6th tier drug is medically necessary.

We have appreciated the opportunity to comment. If you would like additional information or have questions about these recommendations, please contact me at 202-249-7222 or Sue_Rohan@hcsc.net.

Sincerely,

Sue Rohan

Sue Rohan
Vice President, Health Policy – Government Programs

[1] See MedPAC June 2016 Report to the Congress: Medicare and the Health Care Delivery System at http://www.medpac.gov/-documents-/reports