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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

Re: CMS-R-262 (OMB Control Number 0938-0763)

To Whom It May Concern:

Health Care Service Corporation (HCSC) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) in response to the "Contract Year (CY) 2019 Plan Benefit Package (PBP) Software and Formulary Submission," published in the Federal Register (82 FR 44416) on September 22, 2017.

BACKGROUND

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 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.

COMMENTS

CY 2019 Plan Benefit Package (PBP) Software

- **Plan Benefit Package (PBP) Rx Section: "Alternative – Enhanced Alternative Characteristics" Data Entry Screen.** For CY 2018, the note on the "Alternative - Enhanced Alternative Characteristics" PBP screen that references the Generic and Brand Gap discount was updated to reflect the following instruction:

  > "The beneficiary cost-sharing for the Defined Standard (DS) gap coverage benefit in CY 2018 is 44% for generic drugs and 35% for brand drugs. The coverage gap discount applies to applicable drugs for all benefit types and must be reflected in each plan's bid.

> Thus, the gap coverage section of the PBP is only intended for those enhanced alternative (EA) plans offering additional cost-sharing reductions in the coverage gap through a supplemental Part D benefit. All other benefit types will NOT enter gap coverage information in the PBP.
>
> Additional reductions in gap cost-sharing offered by EA plans represents cost-sharing that is significantly better than the defined standard cost-sharing benefits for generic and/or brand drugs that must be offered by all plans. When offering additional cost-sharing reductions for applicable drugs in the gap, the plan liability is first applied to the plan-negotiated price followed by the manufacturer coverage gap discount for applicable beneficiaries.
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> Please note, the additional gap cost-sharing entered in the PBP is meant to reflect the cost-sharing experienced by the beneficiary at the point of sale. The maximum additional gap beneficiary cost-sharing for generic drugs in CY 2018 is 24%. The CY 2018 maximum additional gap cost-sharing for applicable drugs is 55%, which is inclusive of the 50% manufacturer discount. Therefore the maximum beneficiary cost-sharing that should be entered into the PBP as 27.5%. The PBP cannot accept fractions of a percent therefore the PBP entry must be rounded to reflect a whole percentage."

As noted previously in our feedback on the CY 2018 bid submission process, we identified several operational challenges with the updated instruction, which are highlighted below along with related recommendations for further refining and improving this section of the PBP tool for CY 2019 and future years.

- *Brand/Generic Tier Structure*. Although the instructions specify that "the additional cost-sharing entered into the PBP is meant to reflect the cost-sharing experienced by the beneficiary at the point of sale" and indicate that the maximum additional gap beneficiary cost-sharing for generic drugs and "applicable" drugs differ, the PBP software does not accommodate reporting of two separate cost-sharing amounts under circumstances where a formulary may include a brand/generic "mixed tier." We recommend that CMS revise the PBP software functionality to reflect the updated instruction and to ensure accuracy.

- *Applicable Drug.* The updated instruction for this section of the PBP refers to both "brand" and "applicable" drugs. For clarity and to ensure consistent reporting, we recommend that CMS clarify how the agency defines an applicable drug versus a brand drug for purposes of reporting in this section of the PBP.

CY 2019 Formulary Submission

- **2019 Tier Model Options.** CMS is proposing three additional Part D formulary tier model options for CY 2019. Specifically, the agency is proposing two new four-tier structures and one new five-tier structure. 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 continues to believe 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. In their June 2016 Report to Congress, 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 continues to strongly recommend that CMS revise the CY 2019 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 appreciate the opportunity to comment. If you would like additional information or have questions about our feedback, please contact me at 202-249-7214 or Dana_Mott-Bronson@hcsc.net.

Sincerely,

Dana Mott-Bronson
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