January 26, 2021

Acting Administrator Liz Richter  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Washington, DC 20201

CMS-5528-IFC

Dear Acting Administrator Richter:

AARP, on behalf of our 38 million members and all older Americans nationwide, appreciates the opportunity to comment on the Center for Medicare & Medicaid Services’ (CMS) interim final rule with comment period on a Most Favored Nation (MFN) Model for Medicare Part B drugs. AARP appreciates CMS’ ongoing efforts to address the unsustainably high U.S. drug prices compared to the lower prices paid in other similar countries.

Older Americans use Medicare Part B drugs more than any other segment of the U.S. population, typically on a chronic basis. For older adults, these drugs are critical in managing their chronic conditions, curing diseases, keeping them healthy and improving their quality of life. From 2015 to 2019, Medicare Part B fee-for-service (FFS) spending increased from $19.4 billion to $29.8 billion (a nearly 55-percent increase) with per capita spending increasing from $583 to $900. Beneficiary cost-sharing under Part B is 20 percent with no out-of-pocket limit, leaving some older adults and people with disabilities with out-of-pocket costs that can reach $100,000 per year or more.1

Like all Americans, Medicare beneficiaries cannot continue to absorb the costs associated with skyrocketing prescription drug prices indefinitely; the median annual income for Medicare beneficiaries is approximately $26,000 and one in four have less than $15,000 in savings.2 Ensuring that beneficiaries can afford their prescription drugs is essential. Equally important is ensuring that prescribing decisions are appropriately focused on choosing the lowest cost therapy to effectively treat a patient.

AARP generally supports CMS’ interest in testing payment changes for certain Medicare Part B drugs with the goal of lowering costs for the program and its beneficiaries. Given recent prescription drug price and spending trends, it is imperative that policymakers find ways to address program spending without reducing beneficiary access to necessary treatments. Thoughtful efforts to reduce prices and program costs are far preferable to maintaining the status quo of unsustainable escalations in beneficiary and taxpayer spending.

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1 https://www.gao.gov/products/GAO-16-12
AARP also supports efforts to ensure that US prescription drug prices are more aligned with the lower prices charged in comparable countries. It is both unfair and unsustainable that Medicare – and American taxpayers – continue to pay the highest brand name drug prices in the world. During a Congressional hearing, we heard directly from drug manufacturers that they make a profit in every country where they sell their products. Yet, drug prices in the United States are at least double what they are in other, similar countries. There is no reason why Americans should be forced to pay the highest drug prices in the world, especially when many of these treatments were developed in part or in full with federal funding. Lower Part B payments for prescription drugs will help taxpayers, not only by lowering their direct out-of-pocket costs, but by also improving the long-term finances of Medicare.

**Current Medicare Part B payment methodology is problematic**

Medicare Part B currently pays prescribers for prescription drugs based on Average Sales Price (ASP) plus an unexplained but statutorily mandated 6 percent (4.3 percent under sequestration) add-on. The add-on amount is generally believed to be for administrative and overhead costs associated with maintaining an in-office or in-hospital pharmacy and also to help ensure access for purchasers of Part B drugs that are unable to negotiate a price at or below the average.

Medicare’s payment amount does not vary based on the price an individual provider or supplier pays to acquire the drug. It also does not take into account the effectiveness of a particular drug or the cost of clinically comparable drugs. Some experts, including the Medicare Payment Advisory Commission (MedPAC), have raised concerns that this methodology encourages the use of more expensive drugs -- since 6 percent of a more expensive drug generates more revenue than 6 percent of a lower priced drug, selection of the higher priced drug has the potential to generate more profit. While more definitive study is needed, AARP believes the likelihood that the current methodology is influencing providers to use more expensive drugs over less expensive alternatives is reason enough to warrant change.

AARP is also concerned that the current Part B payment methodology does not provide Medicare with adequate leverage to address escalating prescription drug prices. The impact of this challenge is evident in recent spending trends, which indicate that Medicare Part B drug spending is growing faster than drug spending in Medicare Part D and the U.S. overall. MedPAC concluded the largest factor contributing to this growth in Part B spending is the increase in the price Medicare paid for drugs. In addition, international pricing comparisons continue to show that Medicare, as well as American consumers generally, continue to pay the highest brand name drug prices in the world.

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The Most-Favored Nations (MFN) Model

The MFN model will be in place nationwide from 2021 through 2027 and will include all providers and suppliers that submit claims for separately payable Part B drugs furnished to Medicare beneficiaries unless otherwise excluded. The 50 prescription drugs included in the MFN model encompass approximately 73 percent of Medicare Part B drug spending, despite accounting for fewer than 10 percent of Medicare Part B drugs.\(^7\) We support efforts to align those payments with the prices paid by other countries that are part of the Organization for Economic Cooperation and Development (OECD). We also note that the MFN price will be phased-in over the first four years of the seven-year model, which will help providers and others in the drug supply chain adjust and adapt as needed.

In addition, rather than paying a six percent add-on of the manufacturer reported ASP to the provider or supplier administering the MFN drug, Medicare will instead make a flat-add on payment of about $149 in 2021 (updated for inflation in subsequent years) that is not subject to beneficiary coinsurance. We share HHS’s hope that moving from a percentage based add-on payment to a flat payment will remove the incentive for providers to prescribe high-cost drugs, which will in turn help to lower out-of-pocket costs for beneficiaries and help save money over the long term for Medicare.

Impact on Medicare Beneficiaries

Importantly, this model is expected to result in lower beneficiary out-of-pocket spending as a result of lower drug prices and related coinsurance. Moreover, beneficiaries will see lower costs as a result of not paying coinsurance on the add-on payments, which will be converted to a flat rate. CMS also indicates that beneficiaries could further benefit through lower Medicare premiums, as well as the potential for lower premiums for supplemental insurance plans to Medicare. AARP strongly supports these meaningful savings for older Americans. Moreover, lowering spending on prescription drugs covered by Part B will also reduce Medicare spending overall and help to improve Medicare’s long-term financial outlook. It is critical that we advance policies that will reduce costs for beneficiaries and the Medicare program.

Additional Beneficiary Protections Needed

AARP appreciates the MFN model protections that ensure that beneficiary cost-sharing is not higher than it would be if the model were not tested. However, we believe that additional protections are needed. Given estimates that roughly one in five Medicare beneficiaries will lose access to necessary drugs, AARP strongly recommends that CMS establish a transparent, comprehensive, and publicly available monitoring process for the duration of the MFN. We also encourage you to develop a transparent and consumer-friendly appeals process for beneficiaries who experience any issues under the new payment arrangement. While we appreciate that the model should help reduce prescription drug prices and costs and encourage prescribing that

ultimately benefits Medicare beneficiaries, beneficiary access and quality of care are equally important and must be closely monitored.

CMS indicates that it will use a patient experience survey to monitor access and care. However, AARP does not believe that a voluntary survey will be sufficient. We strongly encourage CMS to use a variety of monitoring techniques, including the Medicare Ombudsman, 1-800-MEDICARE, and the State Health Insurance Programs, among others, to ensure that there are adequate dedicated funding and personnel to identify potential access problems and react as soon as is practicable if access problems are identified. Further, CMS should develop a well-defined, transparent process for prompt corrective action—up to and including suspending the model—should it become aware of widespread problems through its monitoring efforts.

CMS should also identify formal processes for regularly engaging and involving Medicare beneficiaries and their advocates. AARP believes it is critically important that multiple, diverse stakeholders have the opportunity to weigh in during implementation and evaluations.

Ongoing Questions About International Price Data Availability

The IFC discusses potential sources of international price data but also recognizes that getting such data may be only the starting point. For example, CMS notes that the data likely will not account for confidential rebates and could therefore overstate net international prices. CMS also recognizes that other countries may find ways to disguise their true net prices if they fear that drug companies will be less willing to extend discounts or otherwise raise their prices going forward.

AARP strongly suggests that CMS develop methodologies to counterbalance or even prevent the manipulation of pricing information, as well as enforcement mechanisms that would help ensure manufacturers provide their international pricing data in an accurate and timely manner.

Longer Timeline Needed

The ultimate impact of the MFN model remains largely uncertain. The IFC offers multiple impact scenarios, including three from the CMS Office of the Chief Actuary (OACT) and another scenario from the Assistant Secretary for Planning and Evaluation. One OACT scenario, labeled “Extreme Disruption Illustration,” depicts physicians and hospitals unable to offer the top 50 drugs within the model and nearly one-half of $286.3 billion in model savings due to beneficiaries who can no longer access medically necessary prescription drugs. Such a scenario would be catastrophic for Medicare beneficiaries. In other scenarios, manufacturers do not lower domestic prices and instead raise international prices. In these scenarios, the anticipated savings from the model may not arise.

These uncertainties and the scope and breadth of this demonstration project suggest that CMS would benefit from additional notice and comment rulemaking to help refine the model before its adoption on an interim final basis. AARP urges CMS to seek additional input and then provide sufficient lead time after the rule is published in final to both lower spending and allow for
successful implementation of any new programs and requirements. Most importantly, we strongly urge CMS to continue its work to reduce prescription drug spending under Medicare Part B. While adjustments and refinements may be needed to this proposal, we do not believe maintaining the status quo is sustainable for Medicare beneficiaries or the Medicare program.

Conclusion

AARP appreciates HHS’s focus on the discrepancy between high U.S. drug prices and the lower prices paid in other developed countries, as well as its ongoing efforts to help lower Medicare Part B drug prices and out-of-pocket costs for the millions of older Americans struggling to afford the medications they need. We look forward to continuing to work with you to make prescription drugs more affordable and accessible for all Americans. If you have any questions, please contact me or have your staff contact Amy Kelbick on our Government Affairs staff at (202) 434-2648 or at akelbick@aarp.org.

Sincerely,

David Certner
Legislative Counsel & Legislative Policy Director
Government Affairs