



February 13, 2023

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health & Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

**RE: Contract Year 2024 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs**

Dear Administrator Brooks-LaSure:

AARP, on behalf of our nearly 38 million members and all older Americans nationwide, is pleased to submit the following comments on the proposed Contract Year 2024 Policy and Technical Changes to the Medicare Advantage (MA) and Medicare Prescription Drug Benefit Program (Part D).

We are committed to ensuring that older Americans have and maintain access to affordable, high quality, high-value health care and ensuring that the beneficiary's perspective is a key component of care delivery. The importance of this commitment is magnified as we have seen significant increases in enrollment in MA plans over the last several years, with MA enrollment expected to eclipse enrollment in traditional Medicare this year. AARP believes that all Medicare beneficiaries, whether they participate in traditional Medicare or Medicare Advantage, should have a genuine choice among coverage options and quality providers.

**Marketing and Communication Requirements for MA and Part D**

Plan marketing can affect consumer experience and, in many cases, lead to consumers enrolling in a plan that does not meet their needs. AARP has repeatedly raised concerns about marketing abuses around MA plans and supported greater oversight, enforcement, and regulation of marketing materials and marketing standards for both MA and Part D plans. We call upon CMS to continue to tighten its marketing requirements -- including significantly improved oversight, better insurer accountability for downstream entities, and greater coordination with other federal agencies and state regulators -- for more effective oversight in this area. Among the proposed new requirements, we support the proposed changes in this rule that would strengthen beneficiary protections from deceptive and abusive marketing practices, including,

- Requiring agents and brokers to explain to consumers the effect of a Medicare coverage option or plan choice prior to enrollment (especially when a voluntary choice to leave an MA plan and return to traditional Medicare may expose the consumer to medical underwriting for a Medicare supplement (Medigap) policy),
- Limiting the time that a sales agent can contact a potential enrollee to no more than six months following the date that the enrollee first asked for information,
- Prohibiting marketing of benefits in a service area where those benefits are not available, and,
- Placing discrete limits around the use of the Medicare name, logo, and Medicare card in marketing materials and other advertising.

We are also supportive of the proposal to add additional requirements for third-party marketing organizations (TPMOs) to disclose that they do not contract with all available plans in each service area when engaging with a potential enrollee. The requirement to make this disclaimer not only in printed materials but within the first minute of any solicitation call will help beneficiaries better understand and evaluate their choices and realize that they may not be getting complete and unbiased information.

A Medicare beneficiary's choice of coverage is highly personalized, complex, nuanced, and likely to evolve over time. With so many options available both in terms of MA and Part D, it is critical that these plans are marketed accurately, and that plan information is communicated in a clear, meaningful way. Plans should not be permitted to bombard individuals with unsolicited marketing, especially once they have made their initial enrollment choice not to enroll in an MA plan. This proposed rule's requirements on MA and Part D plan marketing will help go a long way to improving the beneficiary experience when choosing what Medicare plan is right for them.

### **Medicare Advantage Provider Directories**

An MA plan's provider directory is an essential resource in ensuring access to care for all enrollees. Despite steps made by CMS to improve the display on Medicare Plan Finder and requirements around relevant information a plan provider must disclose, it can still be exceedingly difficult for consumers to meaningfully assess and compare plan networks. The increasingly high number of plan choices and growing complexity of tiered provider networks can make it extremely hard for consumers to focus on what type of coverage is best for them. Given the choice between Medicare options – let alone MA plan options – consumer access to personalized and unbiased information is critical.

We support the proposed language that would require MA providers to state, “each provider’s cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the (medical) provider’s office.” Additionally, we appreciate language directing MA providers to follow the Office of Minority Health’s definition of “cultural and linguistic capabilities” which are defined as “services that are

respectful of and responsive to individual cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs.” Additionally, we are supportive of the proposal that an MA plan’s online provider directory be searchable and comparable by every element -- such as name, location, and specialty -- that is required in CMS’ model provider directory in addition to the health care provider’s cultural and linguistic capabilities.

### **Ensuring Equitable Access to Medicare Advantage Services**

Ensuring health equity for all Americans across racial, geographic, and other categories is among the most pressing challenges our health care system currently faces. We applaud CMS’ continued dedication to eliminating disparities for enrollees in MA plans, especially steps to make services available to all Americans by expanding the availability of language services. We support the proposed expansion of MA plan provider requirements to ensure that services provided are culturally competent. We agree that the proposed change of categorization from “Cultural considerations” to “Ensuring Equitable Access to Medicare Advantage Services” is a more suitable description given the new list of protected classes proposed, including the addition of “people otherwise adversely affected by persistent poverty or inequality” and “people who live in rural areas and other areas with high levels of deprivation.”

Additionally, we urge CMS to monitor the effects of current MA payment policies on disparities in access to and quality of care and to address any unintended consequences. For example, recent evidence suggests that current MA payment policy may discourage insurance carriers from offering high quality plans in areas with many residents from diverse racial and ethnic backgrounds.

CMS could consider requiring MA organizations to develop and report progress on equity impact plans for addressing disparities at the beginning of each plan year. The equity impact plan would describe internal operational and cultural changes required to advance health equity among MA enrollees. In addition, CMS could require MA plans to describe how they will identify and address beneficiaries’ social determinants of health.

### **Quality Improvement Program**

We are supportive of the proposal to amend MA Quality Improvement (QI) program regulations to improve the quality of care and health outcomes for MA enrollees and advance health equity. QI programs have served as a vital tool to help MA plan providers focus on how to address disparities and holding plans accountable. Incorporating one or more activities that are meant to reduce disparities into their QI programs will help to further reduce disparities in health care among their enrollees. The examples provided – improving communication, developing, and using linguistically and culturally appropriate materials, hiring bilingual staff, and engaging in community outreach – are good examples of actions that have helped reduce disparities in communities across the country.

## **MA/Part C and Part D Prescription Drug Plan Quality Rating System**

AARP appreciates CMS' ongoing efforts to ensure that the Star Ratings system is continually improving. We appreciate that CMS is continuing to refine the system by adding, removing, and updating measures, by revising cut point methodologies for certain measures, and by revising measure scores where there is a contract consolidation. These updates help to ensure that the quality rating system is patient focused and helping to guide beneficiaries to find the best plans and providers. Meaningful, accurate, and reliable information about quality and costs are essential to empowering beneficiaries and actively engaging them to make the best choices for their own health care

## **Expanding Eligibility for Low-Income Subsidies Under Part D of the Medicare Program**

As a result of the new prescription drug law, starting January 1, 2024, the full Medicare Part D low-income subsidy (LIS) will expand to include individuals who are eligible for the partial LIS benefit. Beneficiaries receiving partial LIS benefits typically pay some portion of their Part D premiums and cost-sharing while those receiving full LIS benefits do not have to pay a Part D premium and are required to pay relatively modest copayments.

AARP strongly supports CMS' efforts to ensure that this important change is implemented in a timely manner. Estimates indicate that more than 300,000 Medicare beneficiaries are currently receiving partial LIS benefits and will see a reduction in their premium and out-of-pocket costs after they transition to full LIS benefits.

## **Mid-Year Changes to Approved Formularies**

AARP supports CMS' efforts to update and streamline processes that allow Part D sponsors to make small-scale, mid-year changes to approved formularies to allow enrollees to benefit from the latest clinical research and new potentially lower-cost options. As CMS notes, prescription drug therapies and clinical knowledge are constantly evolving, and change will inevitably occur over the course of the year. Thus, it is important for Part D sponsors to retain some flexibility to make midyear formulary changes to help ensure that enrollees can benefit from such changes as quickly as possible. However, AARP agrees that such flexibility should be appropriately limited to ensure that mid-year formulary changes do not negatively affect enrollee access or become so expansive that they lead to "bait and switch" concerns.

AARP also strongly supports CMS' ongoing efforts to ensure that affected enrollees receive appropriate notification of midyear formulary changes, as well as information about steps they can take to request coverage redeterminations and exceptions. Early and clear consumer notification is critical to ensuring that formulary changes do not disrupt enrollees' prescription drug regimens. CMS should monitor plan notification and hold plans accountable when and if the timeframes and standards are not met.

AARP also supports CMS' proposal to allow Part D sponsors to immediately substitute a newly released interchangeable biologic, unbranded biologic, or authorized generic and remove its corresponding brand name equivalent from the formulary, as is currently the practice with

generic drugs. Such substitutions have the potential to create substantial savings for consumers and the Medicare Part D program. However, while we appreciate why CMS has chosen not to extend this policy to non-interchangeable biosimilar products, we believe it is noteworthy that the US Food and Drug Administration's (FDA) position is that, "All FDA-approved biosimilars, including interchangeable biosimilars, must be highly similar to and have no clinically meaningful differences from the reference product in terms of safety and effectiveness."<sup>i</sup>[ii](#) As such, we strongly encourage CMS to continue to engage with FDA to determine when all biosimilar drugs can be immediately substituted for their brand name counterparts.

### **Part D Medication Therapy Management (MTM) Program**

AARP applauds CMS' ongoing efforts to improve participation in Part D MTM programs, particularly given CMS' longstanding concerns that plan sponsors are using restrictive eligibility criteria to limit the number of potential enrollees. The proposed changes to the MTM targeting criteria will require Part D sponsors to include 10 core chronic diseases, lower the maximum number of covered drugs a sponsor may require and require sponsors to include all Part D maintenance drugs, and revise the cost threshold methodology in a manner that better reflects the high generic utilization rate in Medicare Part D. CMS estimates that these changes will more than double the number of Part D enrollees who are eligible for MTM services. AARP strongly believes that MTM programs provide critical services that help maintain the wellbeing of Part D enrollees and appreciates CMS' effort to improve enrollee access to such services.

### **Limitation on PDP Contracts Held by Subsidiaries of the Same Parent**

AARP supports CMS' proposal to limit the number of PDP contracts held by subsidiaries of the same parent organization to one PDP contract per region. Given the number and scale of mergers that have occurred in the Medicare Part D plan market, this represents a timely and important change. Moreover, while we appreciate that CMS' goal is to ensure that plans are truly competitive, this proposal has the potential to align with CMS' ongoing efforts to ensure that Part D plans are meaningfully different from one other. Although the number of Part D plan offerings is not as high as in Part D's past, the average Medicare beneficiary still has a choice of nearly 60 Medicare Part D plans in 2023, including 24 Medicare stand-alone drug plans and 35 Medicare Advantage drug plans.<sup>ii</sup> [iii](#) Even the most engaged Medicare beneficiaries could struggle to sort through such a high number of plan options, which could be contributing to the relatively low number of enrollees who review their plan options annually.<sup>iii</sup> To the extent that this proposal reduces the number of what may be very similar Part D plans in a given region, it could have the added benefit of making enrollees' plan decisions somewhat easier.

### **Shortages of Formulary Drug Products During a Plan Year**

AARP supports CMS' proposal to require, for the duration of a drug shortage, Part D plan coverage of alternative therapeutically equivalent products in lieu of the product in shortage. As CMS notes, drug shortages have been a concern for decades and received renewed attention because of supply chain disruptions during the COVID-19 pandemic. Given that the underlying drivers of drug shortages remain largely unaddressed, there is little reason to believe that such events will not continue to occur in the future. Individuals who are reliant upon medications that

are in shortage should not have to face the possibility of being unable to access suitable alternative drugs if they are available. As an added beneficiary protection, AARP encourages CMS to consider developing recommendations for how Part D plan sponsors should respond to drug shortages when no therapeutically equivalent products are available.

Thank you for the opportunity to comment on these important issues. If you have any questions, please do not hesitate to contact me, or have your staff contact Brendan Rose on our Government Affairs staff at 202-434-3770 or [brose@aarpp.org](mailto:brose@aarpp.org).

Sincerely,

A handwritten signature in black ink, appearing to read "David Certner", with a long horizontal flourish extending to the right.

David Certner  
Legislative Counsel and Legislative Policy Director  
Government Affairs

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<sup>i</sup> <https://www.fda.gov/media/154917/download>

<sup>ii</sup> <https://www.kff.org/medicare/issue-brief/medicare-part-d-a-first-look-at-medicare-drug-plans-in-2023/>

<sup>iii</sup> <https://www.kff.org/medicare/issue-brief/a-relatively-small-share-of-medicare-beneficiaries-compared-plans-during-a-recent-open-enrollment-period/>