January 27, 2025

Acting Administrator Jeff Wu
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard, Baltimore, MD 21244

Submitted via www.regulations.gov

Re: CY 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (CMS-4208-P)

Dear Acting Administrator Wu,

The Alliance of Community Health Plans (ACHP) is pleased to again partner with the Trump Administration to strengthen and expand the Medicare Advantage and Part D program to increase competition, protect consumers and deliver value for every Medicare dollar. President Trump promised it's time to "go wild" on health and medicine to make America healthy again and we remain a valuable resource to help deliver on that promise. We write with comments on the proposed CY 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Programs and PACE regulation.

ACHP is the only national organization advancing a unique payer-provider aligned model of health care that fosters true competition, delivering high-quality coverage and care. As regional, non-profit insurers, ACHP member companies provide affordable coverage options to tens of millions of Americans in nearly 40 states and D.C., remaining in their markets even when other carriers exit. The sustainability of regional health plans is of paramount importance to an innovative and competitive insurance industry, ensuring consumers have robust choices for their health coverage.

While ACHP offers comments on a wide array of the provisions within this proposed rule, we raise the following comments for the Administration's priority consideration:

1. **Biden Health Equity Index:** ACHP strongly recommends eliminating, or at the very least delaying, the implementation of the Health Equity Index (HEI) and reinstating the Medicare Advantage Reward Factor. The Biden Administration's HEI is a poorly designed policy that does not incentivize closing gaps in care delivery and leaves out millions of consumers most affected by risk factors resulting in poor health outcomes. In many communities, particularly in rural regions, health plans can't even compete for the reward. This is anticompetitive, harms vulnerable consumers in underserved areas and is antithetical to quality investment. ACHP-commissioned modeling by Wakely Consulting Group shows that while nearly the entire nation has the requisite number of seniors with defined social risk factors to qualify for the HEI, more than three-quarters are enrolled

in health plans that are ineligible for the full reward. This is a clearly broken policy that should be halted.

The MA Stars Reward Factor, which recognized consistently high-performing health plans, should be reinstated immediately. It is incomprehensible that health plans demonstrating the longest and strongest quality records would not be incentivized to continue to deliver that standard of care.

2. **Coverage of GLP-1s:** ACHP does not support the proposed Part D and Medicaid coverage of GLP-1s. It is imperative the Administration address the disproportionate and exorbitant costs of these medications for Americans compared to the rest of the world, establish appropriate prescribing practices to prevent overutilization and wait for long-term safety and efficacy data before expanding coverage.

3. **Supplemental Benefit Marketing Restrictions:** ACHP does not support the Biden Administration's proposed restrictions on marketing supplemental benefits which could significantly hinder plans' ability to effectively communicate offerings. This could limit the ability to showcase unique value propositions, making it harder for consumers to understand the full value of a plan's benefits. Additionally, the removal of the content standard from the marketing definition and the sole reliance on the "intent standard" is inherently subjective. Organizations may struggle to understand how CMS will classify materials as communications or marketing. This uncertainty could lead to competitive disadvantages for plans that interpret the guidance more strictly than others.

We look forward to partnering with CMS to finalize a regulation that will advance a MA and Part D program that works better for consumers and delivers a more affordable and higher-quality benefit. Our full comments include:

Part D Coverage of Anti-Obesity Medications

ACHP opposes the proposed Part D and Medicaid coverage of GLP-1s for obesity. CMS' reinterpretation of the statutory exclusion of "agents when used for anorexia, weight loss, or weight gain" to covered Part D drugs under Medicare and Medicaid is wrong. The new Loper-Bright standard limits the Administration's discretion and poses a risk of undermining the statute's clear and precise language, crafted by lawmakers with deliberate intent, and should be regarded as an overreach in applying an unambiguous exclusion.

CMS must address the underlying price of anti-obesity medications prior to coverage expansion. The price of GLP-1s for Americans is unsustainable. Manufacturers charge Americans $969 a month for Ozempic and $1,349 a month for Wegovy, while Europeans pay less than $100 a month for the same medications[1]. Expanding coverage without addressing the underlying price and considering the impact to the American health care system is irresponsible. The current batch of GLP-1s also enjoy a median of 19.5 patents filed and 18.2 years of exclusivity after FDA approval[2]. The absence of near-future FDA-approved generic GLP-1s indicated for weight management calls for immediate attention and action from

[1] Kenan Institute of Private Enterprise. (2023, January 19). *GLP-1 pricing conundrums continue.* UNC Kenan-Flagler Business School. https://cboh.kenaninstitute.unc.edu/publication/glp-1-pricing-conundrums-continue/.

[2] Gambino, M., Brieger, R. A., & Klein, M. (2023). The evolving landscape of GLP-1 treatments: Market exclusivity and therapeutic advancements. *PMC National Library of Medicine*. https://pmc.ncbi.nlm.nih.gov/articles/PMC11457043/#:~:text=of%20market%20exclusivity%3F,-Findings%3A,yet%20emerged%20on%20these%20products.

policymakers. The lucrative tangle of regulatory gimmicks, dubbed "patent thickets," will once again block more affordable generics and ensure market dominance for the higher-priced brand products. The recent inclusion of GLP-1s on Medicare negotiated drug list should help cost dynamic, however patent thickets should still be addressed as negotiation of the ten drugs has limited scale. In addition, GLP-1 studies indicate that patients must remain on GLP-1s in perpetuity – or risk regaining weight and losing the associated benefits. Without access to more affordable options, health plans face unsustainable cost increases to meet prescribing trends and patient demand for these medications.

Clinical flexibility is necessary to ensure GLP-1s are in the best interest of each patient. Current evidence only supports the use of GLP-1s for weight management in conjunction with physical activity and a reduced-calorie diet. Medication adherence has also proven to be essential for patients to maintain weight loss resulting from GLP-1s in combination with lifestyle changes. However, GLP-1s have significant side effects that can lead to discontinuation or poor medication adherence, such as acute kidney injury, gallbladder disease, acute pancreatitis and significant GI effects. Unintended muscle loss alongside weight loss has also been identified while the long-term effects on the heart muscle continue to be studied. Recommending GLP-1s broadly for obesity without fully understanding the side effects of the increased dosage and prolonged use is wrong. GLP-1s are not passive drugs, and individual patient characteristics and needs need to be assessed before prescribing.

The Administration should focus on the exorbitant costs and appropriate utilization of GLP-1s prior to required coverage in Medicare and Medicaid. Adding costs to these programs is justifiable when the treatments show proven, measurable benefits. The Congressional Budget Office's 2024 report estimates that covering GLP-1s in Medicare alone could increase federal spending by $38 billion over the next decade[3]. CMS itself projected a $30 billion increase in Medicare and Medicaid spending over the next decade.

A 2024 Prime Therapeutics study found that individuals without diabetes who started GLP-1s for obesity had an average of $4,206 higher health care costs in their second year compared to similar members not using the drug. The study also showed no reduction in obesity-related medical events over the first two years of therapy[4]. The exorbitant costs of these medications are exacerbated by recent utilization and prescribing trends. From August 2021 to July 2023, Prime Therapeutics observed a significant increase in the use of GLP-1 medications. The number of prescriptions filled nearly doubled, rising from 5,856 in August 2021 to 9,950 in July 2023. In addition, to appropriately capture risk for MA beneficiaries with obesity, CMS would also need to create Hierarchical Condition Category (HCC) or Prescription Drug Hierarchical Condition Category (Rx-HCCs) codes for obesity, not just morbid obesity.

ACHP recommends CMS incentivize treatment of the underlying causes of obesity rather than only short-term solutions. Obesity is a chronic disease that requires long-term management. Many beneficiaries, especially those in Medicare, suffer from comorbid conditions linked to obesity, including diabetes, heart disease and sleep apnea. Weight loss is just a component of a comprehensive approach to managing these conditions and does not address the root causes of obesity, anorexia or other weight-related issues.

[3] Congressional Budget Office. (2024, December). The economic effects of the proposed policy changes. *Congressional Budget Office*. https://www.cbo.gov/publication/60816.
[4] Prime Therapeutics. (2024, December 27). Prime Therapeutics GLP-1 research Year 2: Cost of care is $4,200 higher for patients with obesity. *Prime Therapeutics*.

It is essential that CMS focus on treating the underlying causes of obesity rather than expanding coverage of medications that only manage symptoms temporarily in some patients. Individualized interventions like nutritional counseling, behavioral therapy and weight management programs are cost-effective and sustainable for managing obesity, without the risks and costs of medications. These programs can also identify each patient's ability to adhere to the necessary lifestyle changes for success with a GLP-1 for weight management, if prescribed. Expanding coverage for weight management services would better align with the long-term health interests of Medicare and Medicaid beneficiaries, reducing dependency on drugs and improving overall well-being. Through the Chronic Disease Pledge, ACHP member companies are committed to improving outcomes for chronic diseases and look forward to aligning on the priorities of Make America Healthy Again. ACHP encourages the Administration to look towards these local, tailored initiatives to address the obesity crisis, rather than rather than relying on GLP-1s as short-term universal fix.

Administration of Supplemental Benefits Coverage Through Debit Cards

ACHP does not support the proposed restrictions on marketing supplemental benefits. CMS' proposed restrictions on marketing the method of benefit delivery and the dollar value of supplemental benefits could significantly hinder plans' ability to effectively communicate offerings. This could limit the ability to showcase unique value propositions, making it harder for consumers to understand the full value of a plan's benefits and choose the best option for their circumstance. Without the ability to advertise the dollar value or distribution method (e.g., debit cards), beneficiaries may perceive a lack of transparency, leading to decreased trust in MA plans.

Additionally, the new guardrails limit debit cards to real-time identification of eligible items, but the technology is not yet widely available to validate the service received through a debit card. For example, a card can only confirm that the dentist is in-network, but it cannot verify the specific service provided. This limitation could severely impact the ability to use these benefits and cards. The proposal would create more confusion than clarity, driving up call volumes to member services and making it more difficult for beneficiaries to compare plans.

Non-allowable Supplemental Benefits for the Chronically Ill (SSBCI)

ACHP supports codifying a non-exhaustive list of non-primarily health-related items or services that are ineligible to be offered as SSBCI. Establishing clear guidelines ensures that only benefits with a demonstrable and reasonable expectation of improving or maintaining the health of chronically ill enrollees are included. This measure helps prioritize the efficient use of program funds, emphasizing services that directly impact beneficiary health outcomes. Additionally, we support CMS rejecting bids lacking sufficient evidence to support the health-related benefit of proposed SSBCI. This proactive approach safeguards the integrity of the program by preventing the inclusion of services that do not meaningfully contribute to the health and well-being of enrollees.

ACHP member companies remain disappointed with CMS' termination of the MA-VBID model and are very concerned about its impact on dual-eligible (D-SNP) populations and low-income

beneficiaries. The loss of SSBCI will limit plans' ability to continue offering benefits based on social needs. We hope the new Administration considers introducing a replacement program or new policies to provide the flexibility to address the needs of these vulnerable populations and communities, many of which are in rural areas.

Ensuring Equitable Access to Medicare Advantage – Guardrails for Artificial Intelligence

ACHP supports requiring MA organizations to ensure equitable service delivery, whether through human or automated systems. Artificial intelligence holds significant promise for improving health care delivery, streamlining operations and enhancing beneficiary experiences. ACHP is excited to work with the Administration to consider innovations in AI; however, guardrails in this rule are critical to ensure that AI tools are deployed ethically, responsibly and without introducing or exacerbating biases. For future rulemaking, we recommend that vendors be required to demonstrate compliance to customers as well to ensure that all industry participants share the responsibility to uphold ethical use of AI.

Medicare Advantage Network Adequacy

ACHP does not support eliminating the network adequacy exception for providers who either do not contract with any organization or exclusively contract with a single organization. Retaining this exception is crucial to maintaining beneficiary access to specialized care, such as behavioral health. Eliminating this exception would worsen access challenges which are already in short supply in many regions. We also recommend that CMS carefully evaluate the potential burden of conducting network adequacy reviews at the plan benefit package level, as this may impose significant operational challenges without clear benefits to beneficiaries. ACHP continues to offer recommendations to improve network composition in our MA for Tomorrow initiative.

Format Medicare Advantage Organizations' Provider Directories for Medicare Plan Finder

ACHP is concerned with the requirement that MA plans attest to the accuracy of provider directory data. Health plans often rely upon the same provider data to meet network adequacy and provider directory requirements. However, providers send their information to health plans without consumer needs in mind despite health plan prompts around consumer scheduling and access considerations. This results in information such as addresses and phones numbers being listed that are accurate for billing, credentialling and network adequacy requirements, but not for consumers' contact needs. Ensuring accurate and reliable provider information is essential, but the proposed approach perpetuates a longstanding provider directory problem. We previously recommended CMS consider developing a centralized "single source of truth" for provider information to address this issue. This would streamline the data submission process and improve efficiency across the program and, when tied into the Medicare Plan Finder, offer more consumer-centric information. ACHP provides a roadmap for improving the accuracy and reducing the administrative burden in our provider directories issue brief.

ACHP does not support including supplemental benefit providers in the definition of "direct furnishing entity." While ACHP recognizes the benefit of supplemental benefit provider transparency, including certain details in the provider directory would be impractical. For example, a vision provider

listing could reasonably include a main address, scheduling line and website; however, listing each branch, retail site and office, which would be subject to the usual opening and closings of commercial entities, would be unnecessary. The entities website would provide far more accurate information for consumer purposes.

Promoting Informed Choice – Enhancing Review of Marketing & Communications

ACHP does not support removing the content standard from the oversight of marketing and communications materials. Determining the intent behind materials is inherently subjective and organizations may struggle to understand how CMS will classify materials as communications or marketing. This uncertainty could lead to inconsistent submissions and potential compliance risks as well as competitive disadvantages for plans that interpret the guidance more strictly than others.

Many materials serve dual purposes such as educating current enrollees while also indirectly highlighting benefits that could influence retention or new enrollment. This overlap in content makes it unclear whether such materials would fall under marketing regulations, potentially discouraging plans from creating educational content for fear of unintentionally triggering marketing regulations. The lack of clear guidelines could lead to inconsistent interpretations across stakeholders.

We also seek clarification on whether advertisements include member materials, which we recommend should be exempt from this guidance. These materials are directed at existing enrollees and plans should be allowed to clearly communicate benefits and usage details. We urge CMS to reconsider the proposed approach and engage in further consultation with stakeholders before moving forward.

Proposed Regulatory Changes to Medicare Advantage and Part D Medical Loss Ratio (MLR) Standards

ACHP supports changes to MLR standards to enhance transparency and oversight, particularly provider incentives and quality improvement expenses. Formalizing the MLR audit process with clear timelines and requirements will strengthen program integrity and accountability. However, we are concerned the proposal does not include unpaid Medicare Prescription Payment Plan (MPPP) balances in the MLR. Unpaid balances represent a cost to the plan and should be included in the numerator, as excluding them would result in an incomplete representation of a plan's financial picture. We recommend CMS further clarify how the proposed changes will address vertical integration which could introduce significant administrative burden for plans. Additionally, plans should be given a longer runway for implementing policies related to MPPP to better anticipate the amount of unpaid balances.

Improving Experiences for Dually Eligible Enrollees – Member ID Cards, Health Risk Assessments and Individualized Care Plans

ACHP supports aligning health risk assessments (HRAs) across Medicare and Medicaid, though we have concerns it will result in an excessively long joint assessment. We recommend a combination of standardized questions and targeted screening to streamline the assessment process and make it more manageable for both plans and beneficiaries.

Thank you for your consideration of ACHP's recommendations to make the MA and Part D programs great. We look forward to partnering with the Administration to drive value, quality and competition. Please contact Michael Bagel, Associate Vice President of Public Policy at mbagel@achp.org or 202-897-6121 with any questions or to discuss our recommendations further.

Regards,

Ceci Connolly
President and CEO
ACHP