

INTERNATIONAL BROTHERHOOD OF TEAMSTERS VOLUNTARY EMPLOYEE BENEFITS TRUST

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DELIVERED VIA ELECTRONIC SUBMISSION

January 16, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4182-P
P.O. Box 8013
Baltimore, MD 21244-8013

<http://www.regulations.gov>

Re: COMMENTS ON CMS-4182-P

To Whom It May Concern:

The International Brotherhood of Teamsters Voluntary Employee Benefits Trust (the “IBT VEBA”) provides Medicare Part D Prescription Drug Plan (PDP) benefits to retired Teamsters and their spouses across the United States and U.S. territories.

Effective as of January 1, 2006, the IBT VEBA entered into an Employer/Union Group Waiver Plan (“EGWP”) direct contract with the Centers for Medicare and Medicaid Services (CMS) to operate a voluntary Medicare Part D PDP. As of January 1, 2018, over 18,000 Teamster retirees and their spouses participate in this program.

In eleven years of operation, we have welcomed efforts by CMS to improve upon the prescription drug benefits available to Medicare beneficiaries. We do not believe these proposed changes to the application of manufacturer rebates and pharmacy price concessions to drug prices at point of sale will improve the prescription drug benefit available to Medicare beneficiaries, and may put greater strain on the ability of PDPs to offer Medicare Part D benefits.

These comments will focus entirely on section 17, “*Request for Information Regarding the Application of Manufacturer Rebates and Pharmacy Price Concessions to Drug Prices at the Point of Sale,*” and will provide commentary from the perspective of an EGWP with respect to the proposed changes. We will assume that other stakeholders will comment in depth on how these proposed changes, as described and modeled by CMS and provided in the proposed regulations, appear to shift prescription drug costs for Medicare PDP beneficiaries from pharmaceutical manufacturers to taxpayers, with only minimal potential savings to a subset of Medicare Part D PDP beneficiaries.

Our main concerns are as follows:

1. **Rebate Trends:** As laid out in section 17 of CMS-4182-P, rebates to plan sponsors did increase between 2010 and 2015. However, we do not believe this will continue. We have seen a decline in rebates as a percentage of drug costs in 2017 and anticipate that trend to continue into 2018, due to blockbuster drugs becoming available as generics, and other changes in drug utilization patterns. In addition, during the period of time in which rebates increased, the average unit cost for rebateable products increased at an even greater rate during those years. If drug manufacturers did not increase their unit costs at rates far greater than inflation, we would not need to rely on rebates to offset at least some of those cost increases. We are also concerned about the high cost of new drugs that have been introduced to market, a trend we expect will continue, and whether these proposed changes will have a negative impact on our ability to negotiate rebates or other methods to reduce costs to our members.

2. **Member Costs:** EGWPs – unlike commercial PDPs – do not make profits from their plans and try very hard to maintain a cost effective benefit. Projected rebates are already shared with PDP members through plan design and premium rates, and are used to offset overall cost increases. Rebates are considered by EGWPs to be an integral part of the revenue stream received by the PDP. If the proposed changes in how rebates are handled result in a reduction in the level of rebates, reinsurance, or gap discounts received by a PDP, other revenue streams received by that PDP will have to increase to offset those reductions. While CMS projects that direct subsidies would increase if these proposed changes were enacted, if the direct subsidy increases did not fully offset the losses experienced elsewhere, such plans would likely have to increase beneficiary costs, either through higher copayments (if fixed copayments are used, rather than percentage coinsurance) or higher premiums, or both.

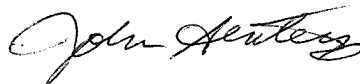
3. **Cash Flow:** Of great concern to us is that implementing these proposed changes could result in another cost that our Medicare Part D PDP would have to cover at point-of-sale, a cost for which it would not be reimbursed for many, many months. As it stands now, EGWPs do not receive the type of prospective payments that commercial Medicare PDPs and MAPDs receive, and must have reserves available to cover these costs at point-of-sale until reimbursements are received. To add a requirement that additional rebates must be provided at point-of-sale could increase this burden, a burden which CMS has recognized and made an effort to reduce in 2017.

Commercial PDPs receive reinsurance, gap discounts and low-income cost sharing subsidies prospectively each month. Prior to 2017, EGWPs received none of these prospectively. Reinsurance and low-income cost sharing subsidies were received in full eleven months after the end of the plan year. The *2017 Call Letter* announced that CMS would begin paying EGWPs some prospective reinsurance to reduce the burden of the long delay between paying claims and receiving such revenue. Because of the nature of EGWPs, CMS determined that the prospective reinsurance amount would be based on reinsurance earned for the plan year three years prior. Any additional reinsurance earned continues to be provided after reconciliation occurs, and received by plans about eleven months after the end of the plan year. This change was greatly appreciated by EGWPs because it reduced strain on cash flow and allowed for plans to better manage cash reserves without requiring unnecessary increases to member costs.

The introduction of the Coverage Gap Discount Program, while also greatly appreciated as a means to provide a lower cost benefit to our members, added to this cash flow burden because coverage gap discounts are provided to members at point-of-sale, but EGWPs do not receive prospective payments from CMS to offset the discounts provided to members and reimbursements for the discounts provided to members are not received by PDPs for many months after members receive the benefit of the coverage gap discount. In addition, rebate revenue is not received by EGWPs for upwards of six months after the corresponding claims are paid. If plans have to include additional rebates at point-of-sale, they will not receive rebate revenue any sooner than they currently receive them and will once again face additional pressure on cash reserves, eliminating some of the relief CMS just provided through earlier payment of some reinsurance amounts.

The IBT VEBA appreciates the opportunity to submit these comments on the proposed changes described in CMS 4182-P. Should you have any questions about these comments or need any additional information, please do not hesitate to contact us.

Sincerely,

A handwritten signature in cursive script, appearing to read "John Slatery".

John Slatery
Executive Director