HTA
HEALTH TRANSFORMATION ALLIANCE

From: **Robert E. Andrews, CEO at the Health Transformation Alliance**

Re: **Comment – Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program**

Date: **January 15, 2018**

As a cooperative comprised of 46 of America's leading self-insured employers, the members of the Health Transformation Alliance (HTA) have come together to fix what is wrong with our healthcare system: rising costs, diminished access, lower quality, sicker patients. While the member owners of the HTA have assembled to achieve superior health outcomes and compelling economic savings, the HTA comprises but a fraction of our nation's limited private self-insured market. Medicare reform, given the significant volume of Medicare enrollees, the volume of services required by its enrollees and the program's vast resources, clearly remains an essential catalyst in achieving meaningful improvements to our health care system. The HTA applauds CMS in its proactive work, especially with regard to its efforts to explore how to manage rising prescription costs.

Along those lines, as CMS looks to evaluate the range of strategies to control Part D spending, here are some reforms the Department should consider that have been successful on behalf of the HTA and the employees, retirees and dependents it serves:

1. *Increase transparency of rebates, discounts and fees*

HTA supports full transparency of the revenue streams achieved through discounts and rebates. This arrangement has produced immense value not only to our member companies paying claims, but also to the plan participants themselves. Transparency can foster more equitable disruption of discounts and rebates, which may then be reinvested to help curb the rising drug costs that are typically passed onto plan participants – either in the form of reduced copays or improved benefits. More transparency may also lead to greater competition based on actual drug price. CMS has obvious opportunities to promote transparency in its relationships with manufacturers and PBMs resulting in greater influence over the treatment of rebates and discounts.

Full transparency means full disclosure of rebates, discounts and fees *at the individual drug-level*, as opposed to only making this information available in the aggregate and thus failing to provide a full and accurate picture. By providing complete drug-level transparency, the HTA has ensured that its companies and their plan participants are able to make more informed decisions about their health care plan choices and better evaluate the economic justification behind specific

drug price determinations. Medicare can benefit from maximizing the transparency of rebates, discounts and fees in the same fashion while increasing accountability of drug manufactures on pricing.

2. *Allow mid-year formulary changes to provide best-in-market pricing*

We support the concept of allowing enrollees to improve their pricing and benefit from formulary changes on an ongoing, semi-annual basis. We would encourage regular "market checks," allowing companies and plan participants to benefit from mid-contract price reductions based on increased competition, availability of new generics and other market changes. Likewise, CMS can reduce costs by allowing for midyear changes to its prescription drug formularies that may provide access to new, better priced generics introduced into the market during the plan year.

We understand the significant challenges facing both the Administration and Congress in implementing meaningful reforms to its Medicare programs. As CMS contemplates ways to help reduce the price of drugs under this rulemaking, we urge CMS to closely consider these recommendations and other strategies being implemented by employers in the private sector that are yielding success and helping to reverse the ever-rising cost trend.