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Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8013
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Attention: CMS-4182-P Request for Information
Docket CMS-2017-0156

Background

Citizens Against Government Waste (CAGW) is a private, nonpartisan, nonprofit, organization representing more than one million members and supporters nationwide. CAGW's mission is to eliminate waste, fraud, abuse, mismanagement, and inefficiency in the federal government. Founded in 1984 by the late industrialist J. Peter Grace and syndicated columnist Jack Anderson, CAGW was established to follow up on the work of the President's Private Sector Survey on Cost Control, also known as the Grace Commission.

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA), enacted in 2003, created Medicare Part D, the prescription drug benefit. The voluntary program allows beneficiaries to pay monthly premiums after enrolling. In 2005, the Congressional Budget Office (CBO) estimated Medicare Part D would cost taxpayers \$172 billion in 2015. As a result of private-sector negotiations, the cost was \$97 billion less or \$75 billion.

Section 1860D-11(i), the non-interference clause in MMA, prohibits the federal government from interfering in the price negotiations among drug manufacturers, pharmacies, and prescription drug plan sponsors. It also disallows creating a specific formulary or instituting a price structure for the reimbursement of covered Part D drugs. Allowing private entities to negotiate drug prices has made Medicare Part D one of the few government programs to cost less than predicted. It also has high satisfaction rates from beneficiaries.

Comments

CMS issued a Request for Information (RFI) regarding the application of manufacturer rebates and pharmacy price concessions to Medicare enrollees at the point of sale. CMS is considering "setting the minimum percentage of manufacturer rebates that must be passed through at the point of sale [POS] at a point less than 100 percent of the applicable average rebate amount for drugs in the same drug category or class."

Regardless of which proposed methodology offered in the RFI is adopted, it would establish price controls and would set precedent for this and future administrations to determine other price structures

within Medicare Part D. It is also a clear violation of the non-interference clause. CAGW urges CMS not to adopt this policy in a future rulemaking.

CMS states in the RFI that the “main benefit to a Part D beneficiary of price concessions applied as DIR [direct and indirect remuneration] at the end of the coverage year (and not to the negotiated price at the point of sale) comes in the form of a lower plan premium” and “the rebates and other price concessions that Part D sponsors and their PBMs negotiate, but do not include in the negotiated price at the point of sale, put downward pressure on plan premiums, as well as the government’s subsidies of those premiums.” However, if a future rule change should require that a certain percentage of rebates must be passed through at the POS, CMS’s own analysis shows that premium increases would occur as a result, costing taxpayers billions of dollars, since they pay for 74.5 percent the Medicare Part D program.

According to tables 10A and 10C on page 56425 of the November 28, 2017 *Federal Register* (FR), requiring 33 percent of manufacturer rebates to be applied at the POS for 2019 through 2028 would result in a 2 percent increase to taxpayers or \$27.3 billion; requiring 66 percent of manufacturer rebates to be applied at the POS would result in an increase of 4 percent or \$55.1 billion to taxpayers; requiring 90 percent of manufacturer rebates to be applied at the POS would result in a 5 percent increase to taxpayers or \$75.5 billion; and, requiring 100 percent of manufacturer rebates to be applied at the POS would result in an increase of 6 percent to taxpayers or \$82.1 billion.

CMS notes in the RFI that when “manufacturer rebates and pharmacy price concessions are not reflected in the price of a drug at the point of sale, beneficiaries might see lower premiums, but they do not benefit through a reduction in the amount they must pay in cost-sharing, and thus, end up paying a larger share of the actual cost of a drug.” However, this process is similar to how Health Savings Accounts (HSAs) work, a policy that the Trump administration seeks to expand. HSAs have been shown to lower overall healthcare costs. A patient pays a lower premium but pays more out of pocket for a healthcare service or product. This encourages patients to shop for the best deal, but more importantly, inserts pressure on all players to lower their costs to consumers.

CAGW is also concerned with the proposal that all pharmacy price concessions be passed through at the POS to beneficiaries. DIR incentives, such as rewarding pharmacies for performance measures, like dispensing more generic drugs, would be lost and could not be used to lower premiums and program costs. According to CMS’s own analysis in Table 11 on page 56428 of the November 28, 2017 FR, this would cause taxpayers to pay an additional \$25.65 per beneficiary per month, or \$16.6 billion between 2019-2028. This proposal is also a violation of the non-interference clause. CAGW urges CMS not to adopt this policy in a future rulemaking.

CAGW appreciates the opportunity to comment on CMS’s RFI regarding the application of manufacturer rebates and pharmacy price concessions to drug prices at the point of sale.

Sincerely,

Handwritten signature of Thomas Schatz in black ink.