COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

1101 14th St. NW, Suite 700 Washington, DC 20005
o: 202.808.8858 w: CAHC.NET

January 16, 2018

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 20201

RE: CMS-4182-P

Submitted Electronically

Dear Administrator Verma:

The Council for Affordable Health Coverage (CAHC) is pleased to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule entitled "Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs For Contract Year 2019" published in the *Federal Register* on November 29, 2017. These comments reflect the positions of CAHC, but may not necessarily reflect the individual views of our members.

CAHC is a broad-based alliance with a singular focus: bringing down the cost of health care for all Americans. Our membership represents a broad range of interests – organizations representing small and large employers, manufacturers, retailers, insurers, patient groups, and physician organizations. Our full membership list is available on our website at www.cahc.net.

Background

CAHC is broadly supportive of the MA program and believe it provides a valuable, efficient alternative to traditional Medicare Fee-for-Service (FFS) for millions of beneficiaries. We further appreciate the overall structure of the program and its ability to support more innovative ways to improve quality for patients and control costs in the Medicare program. The inherent value of the program has been reflected in the increasing enrollment in all sectors of MA over the past several years. CAHC generally supports endeavors to strengthen and enhance the program.

Likewise, Medicare Part D provides prescription drug benefits through a competitive model that has kept premiums low and tax payer costs well below expectations.

Our comments are focused on the following areas:

1. Flexibility in MA benefit design;

2. Treatment of follow-on biologics as generics for LIS catastrophic and cost sharing;
3. Request for information on DIR and point of service rebates;

CAHC's comments on specific policy proposals are found below. These comments reflect the positions of CAHC, but may not necessarily reflect the individual views of our members.

Comments

1. Flexibility in MA Benefit Design

For those with chronic conditions, certain costs are unavoidable, such as insulin for diabetics. Insurers have experimented with creating specialized plans that target and improve care for consumers with higher-cost conditions such as diabetes, mental health, and heart disease. Allowing MA plans greater flexibility to cover these expenses would improve access to medications and services. For example, a plan might be designed to have lower cost-sharing for drugs commonly used to treat depression and mental health providers while also incorporating care coordination for the condition within its core services to help prevent comorbidities or condition deterioration. Insurers should be allowed to market and tailor plans to meet the needs of individuals with specific conditions.

Such specialized benefits can help insurers keep enrollees with higher-cost conditions healthier, positively impacting premiums while also lowering consumer out-of-pocket costs.

We support CMS' proposed changes to the uniformity requirement in the Medicare Advantage (MA) regulations at § 422.100(d). This will permit MA organizations the ability to reduce cost sharing for certain covered benefits, offer specific tailored supplemental benefits, and offer lower deductibles for enrollees that meet specific medical criteria, provided that similarly situated enrollees (that is, all enrollees who meet the identified criteria) are treated the same.

2. Treatment of Follow-On Biological Products as Generics

CAHC supports CMS' proposed revision of the definition of generics to include biosimilars for purposes of LIS cost sharing and non-LIS catastrophic. This will encourage biosimilar use among beneficiaries by lowering cost sharing, while generating more price competition, expanding access for beneficiaries, and helping to restrain growth in program spending, especially in the catastrophic benefit.

We appreciate CMS' recognition that there are distinct differences between biosimilars and generic products, and treating biosimilars as "generic drugs" for other parts of the benefit would not be appropriate. We ask CMS to ensure this proposal not be applied to other parts of the benefit in future years to avoid creating confusion or potentially signaling product interchangeability where it is not appropriate.

3. Request for information on DIR and point of service rebates

CAHC appreciates CMS' request for information and proposal to require plans to pass through a percentage of manufacturer rebates and pharmacy price concessions to beneficiaries at the point of sale. We support CMS' goal of reducing beneficiary cost burdens and encourage you to continue to explore the dynamics and trends in drug and pharmacy pricing, manufacturer rebates and the impact of plan and manufacturer behavior on Part D affordability, especially the impact of these trends on beneficiaries and taxpayers.

We encourage you to carefully consider requiring point of sale rebates, recognizing the trade-offs inherent in the proposal across out-of-pocket costs, premiums, taxpayer costs, incentives for all players, and increasing government requirements on plans. We appreciate CMS first collecting information from stakeholders. We suggest testing the concept as the next logical step to gauge how plans, manufacturers and beneficiaries will react to mandated point-of-sale discounts. Based on the results of the demonstration, CMS could make a better-informed decision on next steps.

When Congress enacted the Part D benefit the authors did not want CMS to micromanage plans or benefits, preferring a reliance on competition to drive beneficiary choices.[1] Mandating plans rebates at the point of sale would lower out of pocket costs for some beneficiaries, but it would also raise beneficiary premiums and some taxpayer costs.

Congress also believed plans would compete on both premium and cost sharing. Congress required plans to provide access to negotiated prices, which take into account negotiated price concessions, including discounts, rebates, DIR and dispensing fees.[2] When manufacturer rebates and pharmacy price concessions are not reflected in the price of a drug at the point of sale, the concessions are realized in lower premiums. Based on data submitted by plans and required by law, between 2010 and 2015, the amount of all forms of price concessions received by Part D sponsors and their PBMs increased nearly 24 percent per year, about twice as fast as total Part D gross drug costs. The DIR data show similar trends for pharmacy price concessions.

While price concessions have lowered beneficiary premiums, they have not generally been passed on at the point of sale in lower cost sharing. As a result, average plan premiums increased just 1 percent per year between 2010 and 2015 and is decreasing in 2018. But also as a result, some beneficiaries are paying higher cost sharing at the point of sale. Higher DIR has also shifted a greater proportion of drug spend into the catastrophic phase of the benefit. This has shifted more costs onto taxpayers as plans are only responsible for 15 percent of costs in the catastrophic phase of the benefit.

[1] Conference Report to accompany Medicare Prescription Drug, Improvement and Modernization Act of 2003 available at https://www.congress.gov/108/crpt/hrpt391/CRPT-108hrpt391.pdf

[2] 1860D-2(d)(1)(B)

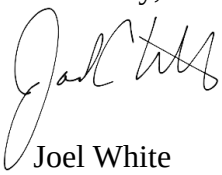
A demonstration approach for POS rebates should not take away from the fact that value based payment – an emerging strategy in commercial plans – should be adopted in Medicare. We encourage CMS to work aggressively to sweep away archaic standards that prevent value based payments, such as those contained in the Medicaid Best price law and anti-kickback statute. These laws prevent coordination and inhibit price discounting based on patient outcomes and should be revised to lower beneficiary and taxpayer costs.

Further, CAHC believes that beneficiaries can benefit from improved prescription drug and plan coverage comparison tools. For example, private sector comparison tools currently provide cost information on the prices of select prescription drugs in various pharmacies to help consumers comparison shop for the best prices. We believe these private sector tools may offer important prescription drug pricing information for Medicare beneficiaries, their families, and other consumers. We encourage CMS to partner with the private sector in new and creative ways to speed public access to these vital tools.

Conclusion

CAHC appreciates your careful consideration of our comments. We stand ready to serve as a resource to you and your staff on the issues related to improving affordability, transparency, and empowerment for Medicare beneficiaries.

Sincerely,



Joel White
President