Pitfalls of POS Drug Rebates and Pharmacy Price Concessions in Medicare Part D

Requiring Medicare Part D plans to pass through to beneficiaries drug rebates and pharmacy price concessions at the point of sale (POS) would be enormously problematic. It would increase Medicare Part D premiums for beneficiaries and program costs for taxpayers, confuse beneficiaries, and help only a small minority of seniors. Currently, pharmacy benefit managers (PBMs) negotiate with pharmaceutical manufacturers and pharmacies on behalf of 266 million Americans, including 42.5 million in Medicare Part D, to lower drug costs for consumers, employers, states, and the federal government.

Mandates to Pass through Rebates and Price Concessions at POS Would Increase Premiums for All Medicare Beneficiaries and Costs for Taxpayers While Providing a Windfall for Pharma

- Requiring POS rebates in Medicare Part D would increase costs to most beneficiaries and taxpayers. CMS estimates that requiring 100 percent of rebates to be passed through at POS would, over ten years, increase government costs by $82.1 billion and beneficiary premiums by $28.3 billion (or 11 percent), and save drugmakers $29.4 billion.[i]
- Medicare Part D *already* requires rebates and price concessions be used on behalf of beneficiaries to improve benefits or to lower premiums.
- Medicare Part D is voluntary; lower premiums encourage younger, healthier beneficiaries to enroll, which balances the insurance risk and keeps the program sustainable.

POS Rebates in the Commercial Insurance Market Are Very Different from POS Rebates in Medicare Part D

- Major insurers and PBMs have pledged to apply manufacturer rebates at POS in commercial group coverage but the practice is infeasible in the individual market and Medicare.
    - In Medicare Part D's stand-alone coverage, PBMs estimate that applying rebates at POS would increase premiums by 17 percent, enough to discourage some beneficiaries from enrolling and potentially destabilizing the program.
- Commercial rebates are available only on fully insured group products. Part D is individual coverage.
- In commercial offerings, the plan/employer can choose to pass through anywhere from none to all of the rebates on all or a subset of drugs and manufacturers cannot game the system.
- For any individual offering, including Medicare, there is a major potential for adverse selection as enrollees would select plans based on the highest rebates for their drugs. Because the risk adjuster does not account well for the sickest enrollees, to avoid disproportionately attracting the sickest enrollees and thus losing money, plans would want to avoid having the highest rebates. Costs could then increase.
- Unlike commercial coverage, Medicare Part D is highly micromanaged by CMS and many of the regulatory underpinnings would make implementation of mandatory POS difficult, costly, and require massive additional regulatory infrastructure.
    - Commercial coverage does not have the complicated multi-benefit phases underpinning the Medicare benefit (e.g., the doughnut hole and the pharma coverage gap discount program) which significantly constrain the structure of the offerings.
    - There is no risk sharing or risk adjustment in commercial coverage, nor PDE (claims filing), reporting or after-the-fact reconciliation process, which would further complicate POS rebates.
- Rebates in commercial coverage do not trigger concerns over violation of the Uniform Trade Secrets Act if a confidential rebate becomes public information.

POS Rebate Proposals Could Subject Part D Plans to the False Claims Act

- CMS has acknowledged that certain price concessions "cannot be reasonably determined at point-of-sale." Therefore, inaccurate estimation of such price concessions could subject plans to civil monetary penalties for unintentionally inaccurate reporting.
- In commercial coverage, plans do not have to estimate rebates but simply can decide an amount to provide enrollees at POS, and so no regulatory issues (e.g., does the beneficiary have to repay the excess?) or legal penalties are triggered when an estimate is off.

Mandatory POS Pharmacy Proposals Would Undermine Statutory Noninterference and Stifle Value-Based Contracting in Part D

- These proposals would undermine the program's noninterference provision, which keeps regulators from interfering in prescription drug plan negotiations with pharmacies and manufacturers and enables plans to innovate and negotiate better ways to decrease costs and increase quality for millions of Americans.
- These proposals would effectively end PBMs' ability to incentivize pharmacy efficiency based on quality performance measures.
- Across Medicare and the rest of the health system, there has been a move away from fee-for-service toward value-based purchasing; pharmacies and drugs should not be the exception.

Public Disclosure of Negotiated Pricing Raises Drug Costs

- Proposals to require public reporting of drug prices net of discounts and rebates would reveal price concessions negotiated on individual drugs by individual PBMs, raising costs for all. Analysts predict disclosure would have a "dampening effect on the magnitude of rebates," potentially increasing brand drug costs more than two percent and federal spending more than $20 billion over ten years.[ii]
- Public disclosure of confidentially negotiated pricing reduces negotiation leverage and undermines competition. The Federal Trade Commission (FTC) has warned of this for decades:
    - **In 2017:** In opining on a California state legislature bill, which would disclose "confidential and other financial information, and to publish that information,"[iii] the FTC references a previous finding that such disclosures, "may harm competition by hindering the ability of plans to negotiate…resulting in less aggressive pricing by, or even collusion among, pharmaceutical manufacturers."[iv]
    - **In 2004:** "If pharmaceutical manufacturers learn the exact amount of rebates offered by their competitors. . .then tacit collusion among manufacturers is more feasible…Whenever competitors know the actual prices charged by other firms, tacit collusion–and thus higher prices–may be more likely."[v]
- Giving competitors knowledge of price concessions of others will actually *raise* prescription drug costs, says the FTC:
    - **In 2004:** Requiring PBM disclosure of negotiated terms could increase costs and "undermine the ability of some consumers to obtain the pharmaceuticals and health insurance they need at a price they can afford."[vi]

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[i] Proposed Rule: 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; 82 Fed. Reg. 56336 (Nov. 28, 2017)
[ii] The Moran Company, "Assessing the Budgetary Implications of Transparency of Prices in the Pharmaceutical Sector," April 2017.
[iii] U.S. Federal Trade Commission, "Letter to the Hon. William Brough, California State Assembly, on A.B. 315, March 31, 2017.
[iv] U.S. Federal Trade Commission, "Letter to Larry Good, Executive Secretary, ERISA Advisory Council," August 19, 2014. https://www.ftc.gov/system/files/documents/public_statements/579031/140819erisaletter.pdf
[v] U.S. Federal Trade Commission and the U.S. Department of Justice, "Improving Health Care: A Dose of Competition" (July 2004)
[vi] Letter from FTC to Rep. Patrick T. McHenry, U.S. Congress, (July 15, 2005); Letter from FTC to Assemblyman Greg Aghazarian, California State Assembly, (September 3, 2004)