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WEBINAR

DRUG REBATES IN MEDICARE PART D
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PARTICIPANTS:

PAUL B. GINSBURG, Moderator
Professor of Health Policy
Price School of Public Policy
University of Southern California
Director
Public Policy, USC Schaeffer Center
and Nonresident Senior Fellow
The Brookings Institution

ERIN TRISH
Associate Director
Health Policy at the Schaeffer Center for
Health Policy and Economics
University of Southern California
Assistant Professor
School of Pharmacy
University of Southern California
Nonresident Fellow
The Brookings Institution

ANNA ANDERSON-COOK
Senior Fellow
Arnold Ventures

MATT PERLBERG
Senior Vice President
Supply Chain
Express Scripts

JOHN O'BRIEN
President and Chief Executive Officer
National Pharmaceutical Council

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P R O C E E D I N G S

MR. GINSBURG: Good morning or good afternoon, depending on your location. I'm Paul Ginsburg. I'm going to be moderating this conference. I stepped down from serving as Director of the USC Brookings Schaeffer Initiative for Health Policy last month.

I'm continuing my roles at the USC Price School in the Schaeffer Center as a Professor and Senior Fellow, and I've been appointed a Nonresident Senior Fellow in Economics Studies at Brookings. Note that I've also served as a Vice Chair on Med Bank. Nevertheless, I'm reflecting my own views and not speaking on behalf of the Commission.

Today's event is focused on our relatively narrow policy issue, how to protect Medicare beneficiaries in Part D who use expensive drugs that are highly rebated from excessive coinsurance payments. The issue is also relevance in many employer-based insurance plans.

And I say excessive because coinsurance is based on the list price for the drug rather than the price net of rebates. In addition to putting forward their ideas on solutions to this issue, our panelists may broaden the issue into areas such as the role of rebates, in engaging competitive forces to constrain drug prices and the appropriateness of current benefit designs.

On the latter issue, it's been a concern of mine for some time that the steep increases in drug prices in recent years have changed the merits of benefit designs based on large deductibles and substantial coinsurance. They've gone from tools to steer patients towards preferred drugs and deter excessive use into large barriers to the use of important therapies and the loss of financial protection that insurance is supposed to provide. And growing rebates has further undermined these benefit designs.

The event will begin with a presentation by Erin Trish, the Associate Director of the USE Schaeffer Center on Health Policy and Economics and a Nonresident Fellow at Brookings on research findings relevant to this issue.

Then our three panelists will offer their perspectives on how the policy should be dealt with. How policy should deal with this issue. First to speak will be Anna Anderson-Cook, a Senior Fellow and philanthropy of Arnold Ventures.

Then we'll hear from Matt Perlberg, Senior Vice President, Supply Chain at Express Scripts. Note that it's Express Scripts is now owned by Cigna and that is well positioned to offering insurer perspectives as well as those of pharmacy benefits managers.

Then we'll hear from John O'Brien, President and CEO of the National Pharmaceutical Council. John served at HHS during the Trump administration, but he'll focus today on his current views about these issues.

Finally, Erin will join the panel to offer her views on policy issues.

Audience questions are welcomed. These could be submitted either by sending an email to events@brookings.edu or via Twitter with #DrugRebates. So I'll turn to Erin.

MS. TRISH: Okay. Thank you very much for that introduction, Paul, and to everyone for being here today. Let me just first confirm that folks can see the screen. If someone on the panel can give a thumbs up or something so I know? Okay. Excellent everybody.

Okay. Well, thank you so much for the introduction and Paul for letting laying that out so well. And to all our panelists and all of our audience for being here and the opportunity to speak today.

So what are we talking about, right? I imagine many of you in the audience may have seen some type of news or research headline recently talking about the growth in drug prices that we've seen over the last few years.

This is research from some of my colleagues at the Schaeffer Center, (inaudible), and Karen in Van Nuys that have shown that we have, in fact, seen these considerable increases in the list prices of existing brand name drugs consistent with some of those headlines that you may have seen.

But what those headlines may have not fully described is kind of what else is going on in this picture? And what they show is that at the same time that we've seen this growth in the list price of drugs, we've also seen quite considerable growth in rebates or these kind of after the fact discounts that manufacturers are paying to plans or to pharmacy benefit managers sometimes known as PBMs to kind of offset the growth that we've seen in the list price of the drugs.

So that when you net all that out and look at the net price of the drug after these rebates and other discounts, we see a different story where the growth or the net prices of these existing branded drugs has actually been quite stable over the last few years.

So I think it's helpful in talking today about Medicare Part D to put this in the perspective of the Part D standard benefit design. This is the 2021 standard benefit design. You can see that, you know, we've successfully filled in the donut hole in the sense that now in this kind of pretty picture of the standard benefit design enrollees pay 25 percent coinsurance on all drugs that they take in the initial coverage period and now in the coverage gap as well.

But, you know, this is I think some other key issues are going on. As Paul alluded to in Part D that

cost sharing is based on the list price of drugs, not the net price. And so, we'll come back in a few minutes to talk about what that means for beneficiaries and how much they're paying out of pocket.

But I think another important thing to kind of recognize here is that beneficiaries move through these phases and progress from the deductible to initial coverage to the coverage gap and ultimately onto catastrophic coverage essentially based on the list price of the drugs.

And so, this set of incentives or this standard benefit design has created a scenario where plans actually have an incentive to prefer these higher list prices with higher rebates because as beneficiaries move through the benefit phases after they've spent several thousand dollars in out of pocket spending, they progress to catastrophic coverage where the plans are no longer the ones at risk for spending but, in fact, the federal government is directly responsible for the vast majority of spending in the form of the federal reinsurance program.

So, you know, this may not seem like such a big deal. It's just this small sliver on top of this benefit design, but it turns out that there's been some pretty considerable changes in the prescription drug market in the last few years. And we're actually at the point now where more than a third of total spending in the Part D program and even more in recent years is occurring while beneficiaries are in that catastrophic coverage or the highest spending coverage region.

And that's led to pretty considerable growth in federal spending on the reinsurance program as well. And so, if we look at that from the perspective of how much the federal government is paying per member, per month in terms of the subsidies to this reinsurance program. This has grown quite considerably over the last decade to the point where the federal government is now directly subsidizing just this high-cost spending region to the tune of about $80 per Part D beneficiary per month.

You know, that's kind of remarkable in its own right but it's also remarkable to compare or contrast that with what we've seen in terms of beneficiary premiums in this program that have been quite flat or quite stable essentially for the entire life of the Part D program.

Average beneficiary paid premium in the Part D program has been about 30 to 35 dollars a month ever since the inception of the program all the way back to 2006. And so, it's quite, you know, remarkable that despite this dramatic change in the overall spending profile and this kind of increase in concentration of high cost drugs that plans have been able to hold these beneficiary premiums so low and so stable.

And this has really been a pretty intense focus in terms of the competitive dynamics in this program as well as policymaker's attention paid to this program. So it might be, you know, I find it remarkable just to even

contrast these two lines. But if you add into that. If you kind of look under the hood of the mechanisms of the Part D subsidy program, it turns out that as the federal government pays more towards these reinsurance subsidies, they actually have fewer dollars to help hold down the beneficiary premiums or to help offset what beneficiaries pay in terms of their monthly premium.

And so, in order to keep these total beneficiary premiums stable that means that plans have had to reduce their bids or essentially what they're telling CMS it's going to cost them or they need to collect each month to cover beneficiaries in this program over time.

So how are plans doing this? How are plans able to essentially provide this coverage with a lower bid over time? Well, there's a couple of different things going on. But relevant to today's discussion, one of the key things at play here is that there's been a dramatic growth in rebates as a share of total spending in the Part D program.

We've seen these are data from the trustee's report where we've seen that it's more than doubled as a share -- that rebates have more than doubled as a share of total spending in the Part D program over the last decade or so. And that's projected to continue to increase.

And so, it's really the case that these kind of after-the-fact transfers of these rebates are enabling plans to keep premiums low to use those rebate dollars to offset or to subsidize premiums in a way that's really helped to keep that line on the previous slide stable or quite flat over time.

So, you know, maybe we're happy about low premiums. Maybe we feel good about that but it turns out that it actually has important implications for beneficiaries in terms of the out-of-pocket spending that they face. And really the value or what's happened to the value of the Part D insurance coverage or insurance benefit over time.

So as I said at the beginning and as Paul described, the beneficiary cost sharing in Part D is a percentage based on the list price of the drug. And so, as the rebates have created this growing divergent where list prices are essentially artificially inflated more and more so relative to the true net price of the drug.

That means that beneficiaries are paying more and more into as a share of the net price of the drug. As that wedge diverges since cost sharing is still tied to the list price, they're now putting more of the bill at the pharmacy counter.

So some colleagues and fellows at the Schaeffer Center, (inaudible) and Mung Lee (phonetic) did some analysis on this and showed that, in fact, beneficiary out-of-pocket spending as a share of the net price, net of all rebates and discounts is actually quite considerably higher than this picture that you see in terms of what we

expect the standard benefit design to cover.

And perhaps most importantly that the excess out-of-pocket spending that this system of trends has created is largest in the most competitive classes, right? So where we have most competition among branded drugs and they're generating the biggest rebates through that competition that's where the biggest wedge is, right?

So we have some classes on the order of 50 to 60 percent where the rebate is 50 to 60 percent of the list price of drugs. So beneficiaries, you know, where we want this competition. We want to kind of share that. The benefits of that competition with beneficiaries. In fact, it's precisely those beneficiaries who are paying the most out of pocket to subsidize the premiums of the rest of the beneficiaries in this program.

So some other work that we've done at the Center to model what might we expect in terms of the change in out-of-pocket spending for beneficiaries if cost sharing were based on the net price of drugs rather than the list price of drugs. And what we find is that about half of beneficiaries, non-LIS beneficiaries in the program would save money from that type of policy change.

And about 20 percent would save more than $100 a year in terms of their out-of-pocket spending or essentially our subsidizing premiums to the tune of more than $100 a year under the current policy.

Just to tie this back to the initial discussion about the benefit phases and the incentives to why plans might prefer this system of higher list prices. We also find that if cost sharing were instead based on the net price of drugs rather than the list price of drugs about a third of the non-LIS beneficiaries who reached catastrophic coverage would not have done so.

So kind of further underscoring this issue that the current status of incentives pushes beneficiaries through the benefit phases faster and is another kind of feature that is attributing to the growth in reinsurance spending and the distribution spending throughout these benefit phases.

So just to kind of summarize the findings. We've seen considerable growth in rebates over the last decade or so and that that's really moderated the growth in net drug prices that use of existing branded drugs. And that this really reflects the system of incentives that are created by the Part D -- the combination of the benefit design and the kind of competitive environment of plans operating in the program.

So this growth in rebates, you know, has helped moderate premiums and keep them quite low and quite stable over time, but I think it's important to point out as, you know, this comes out quite often in the policy discussion about how premiums might increase. I think it's quite important to recognize that today premiums are low because beneficiaries are helping to subsidize those premiums through higher out-of-pocket spending at the point of

sale. And that's particularly true among beneficiaries taking the most drugs in the most competitive classes.

So I think, you know, there's a now, an important policy discussion about what do we do about it? And what might be the implications? And how can we restore the value of the Part D benefit as part of a broader discussion of policy reforms? And so, I'll turn it back to Paul to kick things off in what I'm sure will be a very exciting and enlightening discussion with our panelists. Paul, you're muted, I think.

MR. GINSBURG: Yes. Actually, we're going to turn first to Anna Anderson-Cook from Arnold Ventures to hear her thoughts.

MS. ANDERSON-COOK: Hello. I'm very happy to be here today to discuss drug pricing policy issues and Medicare Part D.

I agree that the growth and list prices that outpace net price growth has caused beneficiaries to pay a greater share of the true cost of drugs which is their net cost. But I have different policy ideas for how to address this.

I want to point out that for beneficiaries taking a preferred brand name drug, they're usually paying initially about $40 for the prescription which is in line with 25 percent of the average price of a non-specialty brand drug. I think that the beneficiaries that are really having trouble are those that have higher spending and enter the coverage gap where they're paying 25 percent of the list price even if they're taking a preferred brand drug. And we all know that beneficiaries that are taking specialty drugs, which can cost $40,000 a year are paying extremely high out-of-pocket costs.

One solution that's been discussed is to pass back rebates at the point of sale that's the Part D rebate rule. And that's an interesting concept but I have some issues with that in that you would be making the discounts and rebates perfectly transparent on a drug-by-drug basis. And economists think that when you make a heavily discounted drug -- when a large purchaser like a large Part D plan or a PBM has negotiated a really good deal then -- but if you make those deals publicly known the net price is likely to increase.

So there are other ways that you could make the Part D benefit more generous to help Part D beneficiaries. One would be to place an out-of-pocket cost, a limit on their out-of-pocket cost. This would particularly help beneficiaries taking high-cost specialty drugs.

Or you could pass back rebates in a more general way. Say, share half or all of the rebates with Part D beneficiaries but the plans could maintain the freedom on how to do that across drugs in order to keep their negotiating leverage.

When you make the Part D benefit more generous, it cost more money and premiums go up. So that's a large reason why the Part D rebate was found to cost $180 billion over 10 years. Much of that was because the benefit was becoming more generous as well as, you know, the size of rebates going down.

So one way policy that you might think of that could help offset those costs that you're going to make the benefit more generous is perhaps have an inflation rebate that when a manufacturer raises its drug price faster than inflation, a rebate is paid to the Secretary of HHS for purchases by a Part D beneficiaries.

CVS has estimated that type of policy could save on the order of $60 billion over 10 years. You could put that back into the benefit to help offset the cost of making it more generous for beneficiaries.

I also think that type of policy doesn't have adverse impacts on innovation because for one thing, you're effecting the revenue stream of new drugs mostly to the middle or end of their product life, which is heavily discounted at the time the investment decisions are made.

And also, you can think of the fact that currently especially for specialty drugs these drugs often have their prices doubled or triple over their product life as they increase faster than inflation. But the rebates aren't very large and increasingly this is where drug spending is going as specialty drug spending as a shared U.S. drug spending has grown from 30 percent to over 50 percent over the last 10 years. So I think addressing this problem is very important.

An inflation rebate means that over a 10-year period of drug price growth slows that means that when there's innovation, you're not getting -- for drugs that a modest innovation over currently marketed drugs, they can expect to get twice as high a price as they do today just because drug prices tend to increase faster than inflation over time.

I think an inflation rebate would help realign incentives so that manufacturers would have less incentive for more incremental innovations and greater incentive to take a risky project that would offer like inventions in a therapeutic class.

Finally, I think we've seen different measures out there about how much faster list prices are growing than net prices. And I think we have to keep in mind that some of these market wide measures of net price growth don't reflect what's happening from the Part D program because they include many discounts and rebates that Part D doesn't get and they include payers that are sheltered from price increases unlike Medicare Part D and commercial plans.

And they also don't reflect what's also happening to the constant brand name drugs as new drugs

are introduced every year. So I think that they average net cost of a brand script has actually been increasing over the last few years even if you account for rebates. Partly because I think net price growth maybe positive and partly because I think beneficiaries are gradually taking a mix of higher priced drugs. Thank you.

MR. GINSBURG: Thank you. We'll hear from Matt Perlberg.

MR. PERLBERG: Thank you, Anna. And thanks, Paul for having us today.

I'm going to attempt to share some slides and so if I could get one of the panelists to just indicate they're able to see the slides? Maybe with a thumbs up? Perfect.

So while I very much appreciate the research and the data that Erin presented. I think it's important that we refocus on truly what the problem is. And I think the problem we're trying to address is not related to rebates or how we deploy rebate value to beneficiaries.

I think the problem we're trying to solve is how do we make drugs more affordable for Medicare beneficiaries? And how do we reduce their out-of-pocket costs? Many beneficiaries are exposed to the high prices for lifesaving medications and that's really the issue we need to solve.

And when you look at the problem that way, reducing patient costs, you quickly find that the rebate isn't the area to target. So let me unpack that a little bit.

Approximately 90 percent of the drugs that are dispensed in the U.S. are generic drugs. These are drugs that have no rebates at all. Of the 10 percent that are brand not all of those are rebated. Now, the amount that are rebated will vary quite a bit across plans and across different formularies, but it's far from all brands.

And so, rebates are impacting a subset of a subset of drugs. It's a fraction of that 10 percent of drugs that are dispensed. And many of the most expensive drugs as I'll talk about in a bit like oncology, rare conditions and Alzheimer's. These are drugs that have a little or no rebates at all.

So if rebates are not the issue than what is it that causes a beneficiary to have high out-of-pocket costs? And it's really two things. The first and the most important and also the most obvious is the cost of the drug itself. And then the second is benefit design. And I'll come back to benefit design in a second.

But let me first talk about just the cost of the drugs themselves. I think it goes without saying that these drugs are extremely expensive. We are talking about drugs that in some cases especially on the specialty side cost tens of thousands, hundreds of thousands or literally now in some cases millions of dollars annually.

And you can see in this chart the average list prices of drugs in certain classes are just astronomical. And as I mentioned many of the most expensive of these -- especially if you go to the right-hand side

of this chart, oncology, rare conditions, immune deficiency. There are practically no rebates at all in these classes.

So for these expensive medications and many others like it, the list price and the net price are exactly the same. So if we're looking at why a patient pays a lot for a drug, the first place to look is at the high cost of the drug themselves.

And I think it's important to note that even when there is a rebate on the drug, the net cost of the drug is very high. And even if we did base a beneficiary's cost share on the net price instead of the list price, the cost to the beneficiary would still be too high.

Let me show a little bit of an example of this. So let's consider a drug with a list price of $100,000 and a rebate of 20 percent. And this is not a farfetched scenario when you're looking at a specialty drug.

Let's further assume that the beneficiary that's taking this drug is in the catastrophic phase of the benefit. So this patient in this example has a five percent cost share. Incidentally, if they were not in the catastrophic phase, their cost share would be even higher. But let's just for the sake of this example say they're in the five percent cost share.

So if their cost share is based on the list price then this patient is going to pay $5,000 out of pocket, five percent of $100,000. If the cost share is based on the net price then the patient is going to pay $4,000 out of pocket. Now, is $4,000 better than $5,000? Well, of course, it is. But that's still unaffordable for the vast majority of beneficiaries. And if our goal in this is to take the out of pocket from $5,000 to $4,000 then I would say, we've missed the point.

Basing a patient's cost share off of the net price instead of the list price. There's no way it is going to meaningfully help the vast majority of beneficiaries afford their medications. The net prices are still too high and again many of these drugs, the most expensive have no rebate at all.

And you'll sometimes hear statistics about how, for example, pharma doesn't receive all of the money that the list price would indicate. You know, there are rebates. There are wholesale discounts. There are 340B discounts. That's true.

It is true that the net price is less than the list price. It is also true that the net price is still really high. And so, whether a manufacturer is getting, in this example, $80,000 because the list price is 80 and there's no discount. Or whether pharma is getting 80 because the list price is 100 and they're giving a discount of 20. You're still getting a lot of money for the drug.

So the high cost of the drug is the single most important driver of the patient's out-of-pocket cost.

Whether you're talking about gross prices or net prices. And so, goal number one for us to reduce the patient cost needs to be, how do we help lower the overall cost of the medication?

And there are ways we can do this. The single most effective is encouraging competition. We know that when we have competing drugs on the market, prices go down. We can encourage things like use of biosimilars and generics. There are a number of patent abuses that we see. For example, manufacturers engage in these schemes where they will literally pay competitors to prevent competing products from coming to market. These are called pay for delay schemes eliminating those practices.

We can allow more value-based programs in Medicare Part D. Many of which we're unable to do today because of the regulatory constructs.

So there are ways to get out of this. And I'm going to touch on -- Paul mentioned a bit at the onset benefit design. And I'm going to touch on benefit design next because I do think there are solutions there. But I think it's important to point out that no matter how we design the benefit, the cost of these drugs if it doesn't change has to be paid for somehow.

Someone is ultimately paying it. And so, if you put the rebates at the point of sale, premiums are going to go up. You don't want premiums to go up. The government would have to pay some other way. This is why when the Congressional budget office, as Anna mentioned, looked at the rebate rule proposed in the last administration, they concluded that it would cost the government about $180 billion in increased premiums.

Now, I am sure that we can quibble with the various assumptions that CDO used to get to their number. But it is undeniable that if the total cost of the drug doesn't change then changing the cost share for the beneficiary is going to necessitate paying for the drug somewhere else. If you squeeze one end of a balloon, the other end is going to inflate.

So one way or another unless the cost of the drug is going down then any policy is just going to move money around. Having said that the second thing that contributes to high beneficiary out-of-pocket cost is the benefit design. And any time where we have a benefit where we're paying a percentage of a number then when that number goes up, the patient's cost share is going to go up too.

And for things like chronic medications especially those where there's little competition or patients have no choice that kind of benefit design just doesn't make any sense.

And Paul alluded to this too at the beginning, but if you go back to why a high deductible health plan or a patient cost share was created in the first place. The idea was to create more intelligent consumers, right?

A patient decides to get their x-ray at urgent care instead of a hospital ER. It doesn't work in a situation where a patient has no choice of what to take or where the medication itself is the cheaper option.

So we need to come up with benefit design options that limit a patient's out-of-pocket exposure. And there are ways to do this as well. We can limit their co-pays on chronic medications. We can also incorporate programs that directly reduce patient out-of-pocket cost.

My organization, Cigna, a couple of years ago wants something called the Patient Assurance Program where we cap the cost of insulin at $25 for a 30-day supply. And we work with manufacturers to get value to the patients directly. That kind of program is not allowed in Med D today.

So there are solutions to the problem, but I think it starts with defining that problem correctly and it's not the rebate. It's how do we make sure that we reduce patient out-of-pocket cost? And when you look at the program that way or the problem that way, you wouldn't gear yourself towards the rebate. There are other policy solutions that I would argue make more sense.

And so, thanks again, Paul, for organizing this panel. I'm looking forward to the rest of the discussion. I'm going to turn it over to John for his opening remarks.

MR. O'BRIEN: Good. Well, thank you, Matt, and thank you, Paul and Erin, for the introduction, the invitation and for presenting your research.

You have taught me more about Part D rebates than anyone except for one person. And that one person was Dan Best, my friend and former colleague at the Department of Health and Human Services. And Dan joined HHS in 2018 because he used to be a top negotiator for CVS. And he understood how this channel worked.

He felt that the rebate system that we had was broken and he shared with us a number of different ways that it was broken. And three years later, I am struck by the stark reminder that today's conversation shows the current rebate system does not serve patients well in Part D or in commercial coverage.

Your slide six shows the growth in the rebates that pharmaceutical companies are providing the payers and pharmacy benefit managers. And a recent Icube report showed that one of three dollars spent on drugs in 2020 went to someone other than the manufacturer thanks to rebates that are negotiated with manufacturers and payers and PBMs. These discounts aren't passed onto patients at the pharmacy counter where they matter most.

We have a system today that actually rewards higher list prices to manufacturers who offer higher rebates frequently get better formulary placement rather than other factors and formulary designs the payers should use that are trying to be more effective for patients in our system.

Now, Erin, your slide showed that net price growth of the price a plan actually pay has been less than inflation for the last three years. But last year, net prices actually decreased by 2.9 percent. What frustrates me about the Part D conversation is the same people that say drug prices are skyrocketing are telling their customers how effective they are at holding that price trend down.

If we don't have a common lexicon for drug pricing policy, we're going to continue to go back and forth about our drug prices going up, our net prices going down or are we are actually seeing decreases in net prices? And I think this is what makes this conversation so difficult to have.

But when bolsters talk about people's perception of drug prices, they're talking about the prices those people pay at the pharmacy counter. Imagine being a pharmacist and explaining to people that the prices plans are paying are going down. But the prices that they are being asked to pay are going up.

NPC's research is showing that medications account for less than one-fifth of what we spend on healthcare in the United States. And yet, drug pricing account for the majority of policymakers focus. This narrow focus often grounded in anecdote instead of data, misses other factors and hinder patient access to medicines and high value care.

This is also effects employers outside of Part D and in their leverage who tried unsuccessfully for years to find out the actual price they're paying for a particular prescription. Instead, they're given aggregate information and promises of rebate guarantees and lower premium.

NPC has written about the importance of prioritizing transparency and providing consumers with point-of-sale discounts when considering new policies. And I think at least half of employers out there think that PBM's lack of transparency about the basis for the decisions they made to exclude or restrict access to product.

We've also written about the importance of following the data to ensure that we are actually pursuing policy that are evidenced based and address the actual issue and truly help patients. Our latest research shows that 35 decision makers at national and regional health plans, integrated delivery networks and PBMs when asked about how potential government involvement in setting drug prices would affect affordability, only one in four respondents said that they would actually pass savings to patients in the form of lower co-pays.

And the vast majority of payers indicated that the coinsurance rate would not change. Most interviewed said that no discount amount would trigger a drop in co-pays or coinsurance rates. And whether that's for political reasons or marketing reasons, everybody cares about keeping premiums low. That is the number that you market on the plan website.

When specifically asked about Part D, the survey responded and said that they saw no impact on Part D prices. Almost three and four respondents said that a 50 percent reduction would be unlikely to change or broaden Part D coverage for branded medications on their organization's formularies.

So the key takeaway again for me is that lowering drug prices was not enough. We need insurers to come to the table and I'm grateful here today for this conversation. And reform benefit design if we're really going to address affordability for patients in the overall healthcare system.

Now, I'll stop there for a second and just say that I heard a lot about the cost of the rebate rule. And I'm not here to defend or praise the rebate rule, but I am very aware of the different cost estimates that were done of that policy. And while the CMS actuary and subsequent Congressional Budget Office analysis had their assumptions, we also went out to the actuary that I think helps the majority of plans with their plan mix.

And they said, well, it could happen this way if nothing happens or manufacturers take the rebates that they're currently offering and hold onto them. But I can't see Part D plans and formulary managers actually allowing manufacturers to take their prices up when they already know what discount they're able to extract from them.

And that's why Milliman found that as you take away the ability to pass on a rebate and prefer a higher list priced drug, PBMs are going to design formularies that are going to force manufacturers to compete on that lowest price to patients. And that when PBMs and Part D plans start forcing them to compete, we would actually begin to see an actual decrease in the price, which would not only help beneficiaries but would also flow through into less of the impact in federal spending. In fact, I think at the extreme end, they showed a 60 to $99 billion reduction as a result of the same policies.

So I'll just stop there and say that there's always assumptions in account metric analysis. I think that same discussion about competitiveness seems to present an opposite case for the comment about economists and transparency. I think manufacturers know what each other's discounts are because they know whether they won or loss in formulary negotiating.

I think the fear is that they may have told this PBM or that PBM that they can only go so far. And there may be a concern about that number getting out there and being pushed even further. But I will end with saying that NPC is a health policy research organization. We work very closely with manufacturers who are our members.

I do not get involved in pricing policy or any of those conversations. I've said at a number of settings that manufacturers alone are responsible for setting their prices and yet the research seems to continually

suggest that the rebate system we have is the reason for the price growth. So with that I look forward to the next question.

MR. GINSBURG: Thank you very much, John. You know, I've got a bunch of questions. Some of my own and some from the audience. But before I get to them, I'd like to give the panelists a chance to actually -- this is going to be in a few minutes.

I'd like to give panelists a chance to, you know, reply to any comments they've heard. But before we do that, I want to go to Erin Trish to get her thoughts.

MS. TRISH: Sure. Thanks, Paul. I mean I'm happy to transfer into the discussion because I think there's a lot of richness here. I mean I think just to kind of touch on -- you know, I absolutely wholeheartedly agree that a broader set of reforms to the Part D program and to insurance design and benefit design more broadly are in store and should be a part of this policy discussion.

This is certainly not the silver bullet. You know, I think that we're all in favor of moving towards a more competitive system that kind of, you know, rewards the highest pricing to value and that, you know, balances the tradeoffs of affordability for patients and rewards to innovation for the patients of tomorrow. And, you know, this is a broad and important conversation to have.

I think, you know, it's just for me and to kind of touch on the points. I think, you know, this intense focus on premiums and what's happening to them and all of this, I think it's just quite important that we make sure we understand the reason why we are where we are. And that, you know, this is really currently across subsidization from out-of-pocket spending for beneficiaries who are paying higher cost sharing at the point of sale.

And that, you know, it's not fair to them. And yes, we need broader reforms to, you know, make things more affordable overall. But we shouldn't lose sight of kind of how this has evolved with sort of kind of under our noses or without recognizing it at least through passive policy decisions.

MR. GINSBURG: Any of the other panelists? So if you would like to say something now before we go to the questions?

MS. ANDERSON-COOK: I think that you can use the Part D dashboard data and information from the trustee's report to show that the average net cost of a brand drug has been increasing over time in Part D. And I also hope we talk more about the benefit design because I think Part D plans share disproportionately in the rebates. And only a small share is used to lower reinsurance costs and a much larger share lowers their share of the costs.

And when they're in the coverage gap, they can even make money on brand drugs because they

only pay five percent but they collect the rebates.

MR. O'BRIEN: There's a lot to unpack in the trustee's report. And there's a lot to unpack into how the benefit design actually functions.

I think the challenge for me is when drug price increase is blamed for an increase in health spending. There's a real difference between the increase in price of drugs and patients who are taking newer drugs that often have newer benefits and a more favorable side effect profile.

So as we start to branch out from discussions about price, the discussions about benefit design to what drugs patients are actually taking that's where I have to step back as a pharmacist and say that the physician uses the drug that is right for them. And I think CMS has continued to push the importance of the real time benefits tools so that the doctor and the patient can actually look at, well, this is what plan you're in. This is what drug is covered. This is what your plan is going to require you to pay or pay on your behalf. And that those kinds of tools are the things that can inform the choice and transparency conversation.

There's also going to be a lot of data coming our way as the transparency and coverage rule begins to take shape. And we're going to see more plan reporting on what their rebates and fees and costs actually are.

So I welcome the conversation about transparency, but I think it's really challenging to just continue to say, oh, it's an increase in drug prices. It's an increase in drug price when we're actually seeing net prices fall over time. And I have to just mention that the CMS actuary -- I believe for a decade or longer now has said, this is what we expect the Part D premium to be.

And then the closer we get to the actual year, we find out that the premium isn't going to be the markedly increased premium we predicted. It's actually going to be something that looks like the premium it was last year. And every year, they use the sentence, we were wrong on the premium because we underestimated the impact of rebate.

And I would just hope that after a decade, we can get our arms around the fact that rebates are distorting the prices and what people are being asked to pay in Part D and that the sick are subsidizing that.

MR. PERLBERG: And I would just say, I mean with all due respect to what John was saying. I think the reason Medicare beneficiaries are paying a lot for drugs is because drugs cost a lot. That's why they're paying a lot for drugs. And whether you're talking about the gross price or whether you're talking about the net price, the cost of the drugs is quite high.

And whether or not if you decided to suddenly say, well, let's put the rebates at the point of sale then somewhere the cost is going to increase to pay for those if the overall cost of the drug doesn't change. It could be the premiums, it could be the government paying more, but somebody is going to have to pay that.

I think, you know, one of the other problems that I see with putting the rebates at the point of sale is, you know, speaking from a PBM's perspective who is going to have to negotiate with these manufacturers and effectively facilitates price collusion among the manufacturers. And even if you use some sort of an approximation of it, it's not going to solve the problem.

I take an example like insulin where, let's say, you know, three manufacturers in the United States of insulin. Let's assume that one has a rebate of 30 percent, one has a rebate of 40 percent of WAC and one has a rebate of 50 percent of WAC. Well, even if you did an approximation. Now the approximation is going to be 40 percent. The one that's paying 50 is going to say, well, there's no point in paying 50. I'm not seeing increased volume for that so they're going to reduce it and pay 40, right?

That's why when economists look at this whether it's in healthcare or any other industry, they say, as soon as you put that out there, the incentive for the manufacturers or the incentive for those providing the discounts is going to be to provide fewer discounts. And so, no matter how you look at this, it's going to -- unless you're reducing the cost of the drug, putting rebates at the point of sale at best increases the cost somewhere else. At worst, increases the overall cost.

MR. O'BRIEN: I would welcome any real world example of a Part D plan covering and preferring a drug where the manufacturer has pulled back the rebate. And look, it's hard because I'm at an organization that prefers speaking about the research that it does itself.

I just find it very interesting that biosimilars and generics are a bullet point on your slide. A bullet point that I happen to agree with. I agree strongly about the value of competition and yet when I wake up, my Twitter feed is full of conversations about brand drugs on generic tiers.

So again, I just think it's very easy for any of us to pick a particular sliver of the population, right? We can talk about the seven percent of the Part D population that isn't using a drug. We can talk about the over 50 percent of the Part D population who is paying a premium that is actually far lower than the drug benefits we're getting. We can talk about the growth in pharmacy DIR and not how pharmacy DIR is paying on generic drugs. So there is a form of rebate on generic drugs that is flowing back to PBMs.

But I would rather have a conversation about solutions that we can get to as opposed to sort of

picking this sliver or that sliver of the benefit and that's what makes this conversation so hard.

MR. PERLBERG: And I would agree with you on picking an overall solution. I think we can agree on that. I would argue that taking rebated drugs is actually only a sliver of the benefit given how much use there is of generics and how not all brands are rebated in the first place.

MR. GINSBURG: Let me get to some questions. And the first one I have is unfortunately it's a little worded question.

An aspect that has made it particularly challenging to address the issues in Medicare Part D would also presume employer plans is that the combination of rapidly growing rebates and cost sharing on list prices has lowered premiums as Erin said, essentially by hallowing out the coverage.

So implementing a way in which cost sharing will be based on, say, approximations of net prices or shifting to an equivalent benefit design emphasizing co-payments will increase federal outlays or in the private sector lead to higher employer premiums. And how can this issue best be addressed?

MR. O'BRIEN: Well, I think the advantages of a system that prefers lower net prices and beneficiaries paying less out of pocket than one that prefers high list prices and high rebates is as attractive to the commercial market as it is the Part D market.

And there are a plethora of employers out there who have sought to learn exactly what their paying at the NDC 11 level for a particular drug, and they are unable to get that information. And often times, when they try to make the change to their benefit design that's going to be good for them or their population, they hear from the PBM that, oh, well, now you're going off of our national formularies. Or you're going to have to forego this amount of rebates.

It's not a rebate that's related to the drug. It's not like, well, you're not paying this drug any -- you're not buying this drug anymore so you're no longer going to get the rebate that's attributable to that drug. It's you're going off of our national template formulary and that's going to change the whole agreement.

Now, I happen to have spent a lot of time with net lost. And I think both Mr. Cordoni (phonetic) and Mr. Wentworth are absolutely right when they say that our customers decide what benefit design, they want to buy from us and how they want to pay it. Some choose spread, some choose retain, some choose pass through, some could choose fix fee if they want.

I just wish we had more transparency where people actually understood the benefits that they were buying and what they're foregoing or accepting by participating in a particular system. And I say that from the context

of someone who has worked both here in the government for a manufacturer but also a health plan. So I've seen how those rebates flow through the system and I've seen how they're treated and it doesn't all go to premium.

MS. ANDERSON-COOK: And Medicare Part D, it does go to the premiums because GEO found that 99 percent of the rebates passed back from the PBM to the Part D plan sponsor.

MR. PERLBERG: I was asked a question about employers.

MS. TRISH: Okay. I agree in the commercial sector. It's less transparent even to the small clients or PBMs especially they may not know what all the rebates are. Whereas larger employers can get 100 percent of the rebate passed through.

But I do think we need to go back to the fact that part of the problem for beneficiaries is, you know, it's a small share of beneficiaries and a small share of prescriptions where the costs are extremely high. It's a large share of the spend and about 30 percent of spending in 2019 in Part D was on drugs that cost $10,000 or more.

MR. PERLBERG: I appreciate very much the question and the comparison to the commercial market because I think we would all agree that, you know, commercial payers are not looking to make money on the benefits that they're providing to their employees, right? That is a cost to most businesses.

We and others in the industry have had point of sale rebates as an option for our customers for literally decades. I think we have between 10 and 20 clients of the 3,000 or so that have actually opted for that. And so, if that were something that they felt were going to reduce their cost or provide additional transparency, we would be seeing a massive uptake on that. That is a widely available -- it's certainly been publicized and yet we don't see that.

And it's because what they find is it doesn't actually increase transparency. It doesn't actually reduce the cost and it's back to what I said before. It's not solving for the vast majority of needs of various patients. And so, it's not a benefit design that's widely used. And if the goal really is to reduce the cost that patients are paying, I think veering towards solutions that are more like limiting co-pays on chronic medications, limiting co-pays on drugs where there's no competition makes a lot more sense than focusing on the rebate which really doesn't impact the vast majority of individuals.

MS. TRISH: I'll just jump in too and say, you know, I think, you know, I 100 percent understand and recognize that the market for prescription drugs is different than the market for other healthcare services.

But, you know, it's not that unique in the grand scheme of things that patients would pay coinsurance based on the negotiated or net price, right? I don't pay my deductible or my 20 percent coinsurance on

the hospital's charge master or their list price of what they would like to charge. I'm paying my coinsurance based on the negotiated price, right?

And so, yes, there's a different kind of set of market dynamics at play here. But it's not that unique in the grand scheme of how we think about this that the cost sharing should be based on the negotiated price, not the list price that's really untethered by these negotiating dynamics.

And so, that's typically how we think about insurance, right, is not that somebody is paying extra out of pocket to -- a sicker patient is using healthcare services is paying extra out of pocket to subsidized the healthy. You know, that's not what we're going for in the system. And so, yes, there are broader reforms that need to happen, but that's consistent with the way that we think about benefit design and other aspects of healthcare.

MS. ANDERSON-COOK: I mean, I'm speaking for Part -- okay. Part D, I think if you're taking a preferred brand on average the co-pay is equal to roughly 25 percent of the net price. But in commercial plans, it would depend on how generous the employer coverage is.

MR. GINSBURG: Okay. Let me go on --

MR. O'BRIEN: I think what Erin is saying is it depends on what, say, the benefit design you're in. Are you talking about a preferred drug? Are you talking about a non-preferred drug? Are you talking about a specialty drug?

When I'm in my deductible, in my high deductible health plan, I don't pay a percentage of the $125 charge for a physical. I pay a percentage of the $60 something negotiated rate. And I understand that the response to that is going to be, well, the drug discount is based on a market share percentage.

And I think we've kind of gotten away from market share discounts, but we have a pretty good way of estimating what the discount is going to be. And, Erin, I think you called it a picture window or a frame and in yours and Paul's paper. But I again think that there are a number of ways to be able to figure out at the point of sale for both pharmacy DIR and manufacturer rebates what the real cost to the patients are going to be. And let's charge them a percentage that's based on what the real cost is.

MR. GINSBURG: We've had a number of questions from the audience about insulin. And as you know, insulin is a widely used drug with rebate percentages that have been very large leading many to face cost sharing that's very high in relation to the net price of the drugs.

And this is perhaps the most visible case because it affects so many people and it's easy to understand kind of. So what is it about insulin that has led to this situation and its visibility?

And there's a second part to the question which let me say now. Is that, of course, the Center for Medicare and Medicaid Innovation has a senior savings demonstration that has capped insulin out-of-pocket expenses to $35 a month. And manufacturers are largely footing the bill for this. But the rebate dynamics on insulin are also extreme. Should we expect more reforms like this for other drug classes absence of type policy changes that we're discussing? And would plans and manufacturers be willing to play along in other drug classes?

MR. PERLBERG: So again, I appreciate the question and it's a travesty that there are individuals that are having to ration insulin or can't afford it. It is an absolute travesty.

What we did on the commercial side in Cigna and Express Scripts shortly after the companies came together was we've launched what we call -- I mentioned it in my opening remarks -- the Patient Assurance program.

And what we were able to do is we worked with the major insulin manufacturers and we capped the cost of insulin at $25 per a 30-day supply regardless of the benefit design. And we were able to work with manufacturers to get that value deployed to the patients in a way that was in concert with that benefit.

That kind of arrangement, we've since expanded it beyond insulin to other medications in diabetes and we're doing so now. And we're targeting to do that in other classes as well. And I think that's a really interesting model of trying to figure out how can manufacturers work with health plans, work with PBMs in order to get value to patients.

What I just described is not allowed today in Medicare. And so, while I appreciate what CMS has done with allowing $35 for a 30-day supply, I think allowing the private sector more of those kinds of programs where we could deploy that value would be a really good way to limit the cost that a patient is paying out of pocket for lifesaving medications.

MR. O'BRIEN: We've been covering the divergence of log insulin that have a lower list price on the preferred tier might also be a way to get there.

The challenges that was explained to me is that there were three manufacturers of insulin and there were the three Part D plans. And three large PBMs that control about 85 percent of the waterfront. And as those negotiations happened, the preference for a larger rebate began to take over the conversation.

And you can follow that conversation over time and you can see the manufacturers now posting in their transparency reports, this is the actual cost of the product. This is what we're actually selling it to the plan for. This is a new version of the same drug that we think should be available at this same price.

There has been so much done to address insulin affordability and I am happy to see the uptake of the senior savings model as it relates to insulin. But you're right, Paul, it's manufacturers coming in and paying their fair share and asking for an exception of the rule so that the discount that they're providing actually flows to the Medicare beneficiaries that they're trying to provide the discount to.

And the thought question that I ask when I'm in classrooms is if you took insulin out of the Part D program and basically gave it away for free. Would the Part D premium go up? Because the size of the rebate that is paid on the drug is more than the actual cost of the goods that are sold.

So it's just an interesting thought question, but I think it's really important to identify what are the high cost, high rebate classes because as we look at the injectable rheumatoid arthritis drugs getting ready to go biosimilar, we're going to have a really interesting conversation on our hands. It will be right back to the who's covering what and why story?

MR. PERLBERG: I think also though this is a good example of why focusing on the rebate is the wrong way to focus if you want to actually reduce the cost of something affordable.

So I'll give an example. At our company, we launched years ago a program called Inside Rx. Inside Rx, is a cash discount card solution for folks that do not have insurance or folks that are underinsured. And the thinking at the time was let's go out to pharma. Let's get rebates that we can deploy at the point of sale for people who don't have insurance. And we thought that was a unique proposition in the cash space and it's still something that we have.

We started off with insulin. And insulin prices, let's say, list prices were about $600. We were able to get them closer to something in the, call it, $300 range, right? Pretty good rebate on those.

What we found is not a lot of up take on the insulin products understandably because $300 is still too expensive. And so, if you broaden that, you mentioned, John, inflammatory conditions, right? Now, you're talking about medications that in some cases are going to have list prices that top $100,000 in a given year and a rebate that even if it's 20, 30, 40, 50 percent is still not going to lead to affordability for a beneficiary.

So unless we're addressing the high cost of the drug itself, we're putting really meaningful dollars towards benefit designs that take a patient's out of pocket from something that's in the 1,000s or 100s to something that's more like 20 to 30. All we're doing is -- we're not really addressing the real issue.

MS. TRISH: I think, you know, insulin is quite important to the -- you know, so the list price spending on insulin actually accounts for about 10 percent of total spending in the Part D program. And I think one of

the important things about this example is that it speaks to some of the issues that Anna was describing, right?

So in the initial benefit coverage phase, it is the case that many plans are using formularies and doing some type of flat dollar co-payment or something to reduce the cost of insulin for beneficiaries who are taking it. But some of the research that we've done has shown that, you know, despite the fact that, you know, there are those formularies in existence in initial coverage on average making insulin about somewhere in the order of $45 or $50 a month for beneficiaries pre the senior savings model taking effect.

The kind of broader set of benefit design issues that are at play in the Part D program even after you filled in the coverage gap, plans essentially have to throw those formularies out the window when the beneficiary moves to the coverage gap.

And, you know, insulin is kind of a good example of the rebate dynamics here because about a third of the spending occurs in the initial coverage period, about a third occurs in coverage gap and about a third occurs in catastrophic.

So it's not the case that these beneficiaries are, you know, entirely in one end of the benefit phase or the other, but they're really experiencing this full gamut. What we show is that their out-of-pocket spending more than doubles in the coverage gap phase and that that's associated with the reduction in insulin. And that's even after in insulin adherence and that's even after we filled in the donut hole.

And that's really speaking to the fact that these beneficiaries are facing coinsurance as based on the list price of the drug when they're in that coverage gap phase that plans can't really get around that with the current dynamics at play.

And I think it kind of speaks to this issue that, you know, these precise beneficiaries are driving so much of the rebate revenue to the Part D program that's really helping to offset premium growth and John's example that he mentioned. And so, I do think that, you know, the kind of insulin story is a good one to focus on in terms of the beneficiary harm that's being created by this system of incentives and kind of the need for broader reforms to address out-of-pocket spending in many ways.

MS. ANDERSON-COOK: And a need to reform the design of the benefit because plans could even be making money on insulin in the coverage gap while the benny is paying 25 percent of the list price and the plan cannot reduce that out of pocket without losing access to some of the manufactured discount. So it's a little bit crazy in the coverage gap and it needs to be fixed.

MR. GINSBURG: I've got another question. Some organizations like the Congressional Budget

office have been given access to Part D rebate data. What research can these organizations do with these data that will be particular useful for policymaking in this area?

MS. ANDERSON-COOK: Before I left CBO, I wrote a report on specialty drugs and found overall that net price growth was positive and trailed list price growth by two or three percentage points.

So I think if, you know, if they could have updated numbers to help, you know, us all be operating off the same numbers. Whether list price growth is growing or not could be helpful. And also, you know, what's increasing drug spend? An updated analysis, you know, of the role of specialty drugs and that could be helpful. And there are many other issues that CBO could help analyze in terms of helping beneficiaries in the Part D program.

MR. PERLBERG: One of the things I would certainly invite CBO to look at because I think, you know, one of the debates we've even been having here is that and I believe John alluded to it. Is, you know, the argument that rebates somehow cause manufacturers to increase prices or cause a high list price.

And so, the analysis I would welcome would be look at classes that have rebates and look at classes that don't have rebates. And do you see differences in terms of the list price? I think what you would find -- certainly, when we've looked at it, but would welcome an independent analysis of this. Is that the list price -- you have very high list prices in classes with no rebates.

You have high list prices in classes with rebates and vice versa. There's not a correlation you're going to find between when you see a high rebate or a low rebate. What you see is a price that the manufacturer sets. And that's, you know, again something I would welcome an independent analysis of.

MS. ANDERSON-COOK: I would also mention that when I studied specialty drugs, I found that they increased in per beneficiary costs from like $10,000 to $30,000 and that the role of new drugs introduced over that period was much of the -- was like just less than half of the increase in that cost. So it's not just year over year. It's mixed as well.

MR. O'BRIEN: Well, I think mixed utilization frequency like all of those are sort of the underpinnings of drug policy research.

And, Matt, I think you know the relationship between list price growth and rebates in competitive classes. I've worked with your folks. I've worked with people like you at other plans. I'm trying to be very honest in describing the supply chain that we have and the way the incentives work.

I'm not here to assign any blame. I'm just saying this is the way the system works today. Drug manufacturers are being blamed for a $350 billion market and about a third of that is actually going somewhere else.

So I think I've made it clear in previous conversations. I think PBMs play a very important part of the conversation. Somebody needs to help negotiate drug manufacturers against each other to get a better deal on behalf of the downstream beneficiaries.

Is that something that a disruptive entity may some day do? I don't know. I feel like we keep having the same conversation here and a number of well-funded public and private actors are looking for something different and nothing is happening.

And traditionally in market places that's when a more disruptive mechanism happens. So I wouldn't be surprised if there are some private market forces that come in and change this system. But the inefficiency and the unwillingness to acknowledge how the rebate negotiation and formulary placement function. Whether or not we're talking about other portions of the benefit. Whether or not we're talking about single source drugs without any other brand or therapeutic competition and their prices, right?

There's a lot of different things we can point to as it relates to affordability. I think what Erin's research has pointed out and the invitation today about -- was what is the role of rebates and affordability?

MS. ANDERSON-COOK: I'm a little confused about the statistics on the supply chain because I'd like to see those numbers for brand name drugs only because generic drugs can cost pennies a pill where the prescription to cover, you know, the pharmacy dispensing is much higher. And so, you're getting a bit wedge on generics. And the generics are 90 percent of scripts. So I'd really like to see those numbers brought up -- broken out separately for brand and generics.

MR. O'BRIEN: And I hope this is not the last time that we talk. I have really enjoyed getting to talk to someone that knows the inside of the CBO process.

MR. PERLBERG: And, John, just on your point. I would say, you know, I have sat in countless negotiations and been a part of countless negotiations with the companies that you represent, that you interact with.

In every single one of those negotiations, the PBM is arguing for a lower price and the manufacturer wants to be paid more, right? Manufacturers want more money. PBMs want to pay them less money.

And so, I think it's important when we talk about rebates and list prices and everything. Sometimes the debate gets a little distorted but at the end of the day pharmaceutical manufacturers are businesses. They are looking to grow their volume and they're looking to grow their revenue. And they raise prices in order to do that.

And the function that we serve is every single time, every single negotiation trying to reduce the price that our plans pay. Trying to reduce the price that beneficiaries pay. So that to me is a critical component of

the dynamic of the supply chain. I just don't want that to get lost.

MR. O'BRIEN: Okay. I just remember a critical care component of supply chain discussions when your leadership and other's leaderships were coming in and having conversations with the Department. So I'm aware of how the market functions and I think we can acknowledge what's actually happening and work on solutions to affordability both in this discussion and in other discussions. Or we can act as independent entities problem.

MR. PERLBERG: And certainly, I welcome all of the discussions around driving affordability, but I would say as the leader of supply chain, one of the largest PBMs in the country that is the dynamic that's happening when you're in the room. Pharmaceutical manufacturers want more money for their drug. We are trying to drive the discounts higher so that they get less money. That's the negotiation.

MR. GINSBURG: We have only about five minutes left in our program. The discussion has been really superb. It's been in depth.

I want to give each of you a chance to have any closing thoughts and steering back to the issue of, okay, what should we do about the situation in Medicare Part D?

MS. ANDERSON-COOK: I would go back to an inflation rebate policy for Medicare Part D that would slow list price growth without, I think without hurting innovation and help pay for a cap on out-of-pocket costs for beneficiaries taking specialty drugs.

MS. TRISH: We have shown that Part D plans are only actually paying about a third of the total spending in the program today. There were a lot of reasons to design the benefit design as it was back in 2003 or for 2006. And the market has come a long way since then.

And I think we -- you know, it's time for policymakers to recognize that. To redesign this program to reinvigorate competition among private plans and kind of be true to our initial understanding that, you know, private plans are here to make these tough tradeoffs about affordability and innovation and access.

But we need to give them the right incentives so that we're getting the outcomes that we want. Not outcomes that, you know, we are blaming on a system that's created a system of incentives that are actually delivering what we're seeing, you know, in a very straightforward way.

MR. PERLBERG: What I would advocate is that we just keep the right problem in mind, which is how do we make sure that beneficiaries are saving money? How do we make sure they're paying less?

And so, for me the solution is focused on, number one, how do we drive the cost of the medication itself down? And then how do we design the benefit in such a way so that patients aren't exposed to high prices?

And I think there are any number of things with all of those that you could do in terms of driving competition on the driving prices down in terms of allowing for more flexibility in the benefit design. Allowing for more limited co-pays on chronic medications and medications with no alternatives so that patients aren't exposed to the high prices of medications.

MR. O'BRIEN: John, I too would welcome a real focus on where the problem actually is. And to me that's what patients are asked to pay at the pharmacy counter.

And I think I've heard a number of different things that we could do today to help patients where it matters most. I agree that this is the benefit that was designed in 2003 to 2005, launched in 2006. And it probably doesn't reflect the market that we have today in thinking about how the benefit is designed, how patient's out-of-pocket costs are kept at the high end. What the different contribution of all the stakeholders in this system is. I think is a really important conversation.

But until then, Erin, I'm going to continue to look forward to research from you and others and look forward to other opportunities to be at the table to talk about solutions.

MR. GINSBURG: Thank you all for this really rich discussion. And thank you to the U.S.C. Brookings Schaeffer Initiative for sponsoring this conference. And I guess we can sign off now. Thank you very much, audience.

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