November 28, 2011

Jon Blum, Director, Center for Medicare
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Subject: Concerns with Part D Plan Restrictions on Use of Generic Zyprexa

Dear Jon:

In light of the concerns regarding the utilization of atypical antipsychotics by Medicare Part D beneficiaries, NCPA would like to bring to your attention a current practice that we believe deserves increased scrutiny by CMS.

NCPA has been made aware of at least two large national Medicare Part D Prescription Drug Plans that will only pay for the brand name version of Zyprexa (olanzapine) at this time. Note that Zyprexa became available in generic form on October 24, 2011. NCPA can only presume this is because pharmacy benefit managers (PBMs) are receiving lucrative rebates from the brand drug manufacturer. Recent OIG reports have questioned the ways in which Medicare Part D plan sponsors allocate rebates. Some PBMs may be deliberately underestimating their rebates in order to increase their profits. CMS should closely scrutinize whether these presumed Zyprexa rebates being obtained by the plan sponsors are truly passed through to CMS and ultimately the beneficiary.

A recent OIG report found that for the year 2008, Part D sponsors received $6.5 billion in rebates, yet some sponsors may be inappropriately allocating rebates across their plans in order to maximize reconciliation payments inappropriately.[1] Notably, according to the OIG, most PBMs did not pass the full amount of rebates on to beneficiaries, and only 4 out of 258 sponsors provided rebates to beneficiaries at the point of sale.[2]

The OIG also found that sponsors underestimated rebates in 69% of their bids and 78% of Part D beneficiaries were enrolled in plans that underestimated rebates.[3] Underestimations lead to higher premiums for Part D beneficiaries and overpayments by CMS. This high percentage of underestimates may indicate that some PBMs deliberately underestimate their rebates in order to increase their profits. There is no consistency, uniformity or transparency in determining whether or how these rebates are going to lower drug costs in these programs.

[1] Department of Health and Human Services, Office of the Inspector General, *Concerns with Rebates in the Medicare Part D Program*, Daniel R. Levinson, March, 2011, OEI-02-08-00050.
[2] *Id*
[3] *Id*

100 Daingerfield Road
Alexandria, VA 22314-2888
(703) 683-8200 PHONE
(703) 683-3619 FAX

Furthermore, the OIG also found in November 2010 in their review of pharmacy discounts in Medicare Part D from 2008 that "for five of the six sponsors, pharmacy discounts were not always passed on to the beneficiaries and the Government."[4] CMS should take action to bring transparency to what happens to these rebates.

The fact that community and long-term care pharmacies cannot dispense the generic version of Zyprexa at this time is extremely unfortunate, as studies show that generic drugs are one-fifth the cost of brand name drugs. It is important to note that in 2010 total sales of Zyprexa were approximately $3 billion dollars, and in many cases this drug has long represented the most expensive product covered by many Medicaid agencies. Nothing can save Medicare Part D more money than, where medically appropriate, dispensing every possible prescription with a generic drug rather than a brand, even after accounting for the lucrative rebates that PBMs earn on brand name drugs.

Yet, Medicare Part D generic dispensing rates remain lower than the national average. The Congressional Budget Office (CBO) recently reported that the generic dispensing rate in Medicare Part D is 64%.[5] This should be compared to a generic dispensing rate by retail pharmacies of approximately 72%.[6] In light of the greater generic utilization-based savings available, NCPA urges CMS to take action to promote the use of generics within Medicare Part D rather than allowing Part D plans to promote the use of more expensive brand name drugs.

NCPA also has similar concerns related to Lipitor, which will have generic versions enter the market in the next few weeks. This is yet another opportunity for CMS to require transparency from the plans regarding manufacturer rebates and associated incentives to require that only brand name products be dispensed. Allegations reported in *The New York Times* over efforts to restrict generic drug use should raise serious questions regarding these practices and the coming wave of generic drugs.

According to *The Times*, some PBMs are instructing pharmacies to fill prescriptions for generic Lipitor with the brand name product only, therefore limiting efforts by pharmacies to substitute the lower-cost generic once it comes on the market Dec. 1, 2011. The deal raises troubling questions that we believe deserve your prompt attention.

Thank you for your consideration of this matter. Please do not hesitate to contact me by email at john.coster@ncpanet.org, or by telephone at (703) 600-1184, if you have any questions.

Sincerely,

John M. Coster

John M. Coster, Ph.D., R.Ph.
Senior Vice President, Government Affairs

[4] Department of Health and Human Services, Office of the Inspector General, *Medicare Part D Pharmacy Discounts for 2008*, Stuart Wright, November 2010, OED-02-10-00120.
[5] Congress of the United States, Congressional Budget Office, *Effects of Using Generic Drugs on Medicare's Prescription Drug Spending*, September, 2010.
[6] *Data from 2011 NCPA Digest, National Community Pharmacists Association.*