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Medicare Preferred Pharmacy Networks

Overview

The Issue: Private insurers participating in the Medicare Part D prescription drug program offer reduced cost-sharing to enrollees who agree to patronize a limited number of "preferred pharmacies." Insurers say they can negotiate price concessions from pharmacies that want to join the narrow preferred networks, providing savings to Medicare beneficiaries and the federal government. But independent druggists say their pharmacies are often excluded from the preferred networks, which have been dominated by national drug chains. The Centers for Medicare & Medicaid Services (CMS) has increased oversight of preferred pharmacies, saying its data indicate some Part D plans do not always offer lower drug prices at preferred pharmacies, or do not have a sufficient number of preferred retailers in certain geographic areas, potentially violating federal rules.

Current Status: CMS in January 2014 proposed rules that would have required Part D insurers to have consistently lower drug prices and cost sharing in preferred networks and to contract with any pharmacy willing to meet such pricing terms. CMS decided not to issue a final preferred pricing rule in May 2014 after insurers and the Federal Trade Commission (FTC) warned it could hamper market competition. In December 2014, CMS released a study that found some preferred networks did not meet Part D convenient access standards. During the 113th Congress, lawmakers introduced legislation to require that preferred pharmacy plans have an adequate number of retail locations, with a focus on rural areas (H.R. 4577).

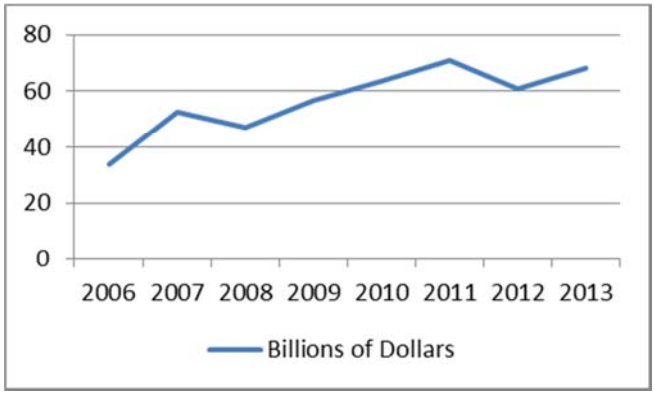
Preferred Pharmacy Networks

Background: Congress created Medicare Part D in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), effective January 1, 2006. The MMA provides a voluntary, outpatient prescription drug benefit for Medicare beneficiaries. Part D coverage is provided through private insurance plans (PDPs) that offer only drug coverage, or private Medicare Advantage (MA) plans (MA-PDs) that offer drug coverage as part of a broader, Part C managed care benefit. All Part D insurers (sponsors) must provide a specified, minimum level of coverage, though they may offer more generous benefits. Enrollee premiums cover about 25.5% of the cost of the standard Part D benefit, with the federal government subsidizing the rest. According to the 2014 *Medicare Trustees Report*, total Part D expenditures in 2013 were approximately $69.7 billion (see **Figure 1**). Total Part D spending has been lower than forecast at the beginning of the program.

Part D sponsors generally contract with pharmacy benefit managers (PBMs) to manage the drug benefit. PBMs carry out functions including negotiating drug prices with manufacturers, creating a formulary or list of drugs to be covered by a plan, and contracting with a network of pharmacies in a plan's service area that agree to accept the insurer's prices and other reimbursement policies. The MMA requires that Part D pharmacy networks provide convenient access to retail pharmacies for all enrollees. Further, a Part D sponsor must permit any pharmacy willing to accept its standard contracting terms and conditions to participate in the sponsor's pharmacy network. This is known as the "any willing provider" requirement.

Once Part D sponsors have met the any willing provider and other requirements, they may differentiate among contracting pharmacies. Insurers may offer plans that designate a subset of network pharmacies as "preferred" if the pharmacies charge lower enrollee cost-sharing than "non-preferred" or "other network" pharmacies. For example, an enrollee may be charged a $10 prescription co-payment at a preferred pharmacy, and a $20 co-payment at a non-preferred pharmacy. *A Part D plan may not designate a pharmacy as preferred unless it designates other pharmacies as non-preferred or other network pharmacies*. Part D preferred pharmacy enrollees may still use non-preferred pharmacies in their plan's network, but face higher cost-sharing than at the preferred locations. However, cost-sharing for Part D low-income beneficiaries (those with incomes up to 150% of the federal poverty level) is set by CMS each year under a national formula. Sponsors may not charge low-income enrollees cost-sharing that exceeds Part D limits.

Figure 1. Annual Medicare Part D Spending



Source: *Medicare Trustees Report*, 2014. Figures are in nominal dollars.

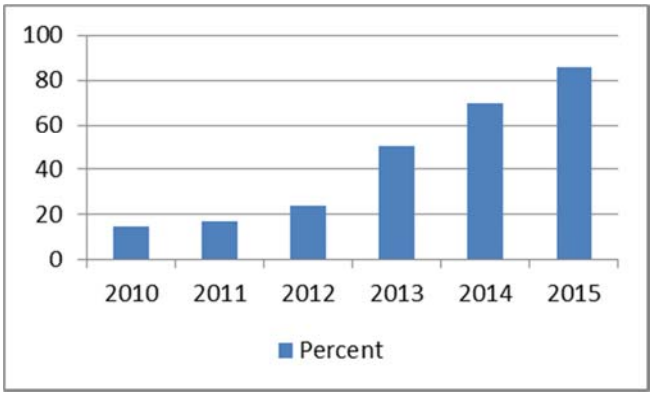
CMS rules also specify that the difference in enrollee costs between preferred and non-preferred pharmacies cannot be set at a level that discourages Medicare beneficiaries in certain locations, such as inner cities or rural areas, from enrolling in that Part D plan. Further, the creation of preferred pharmacy networks must not result in increased

federal payments to a Part D plan. CMS does not have detailed guidance on constitutes increased plan payments, but has said sponsors should be negotiating lower drug prices for drugs dispensed by preferred pharmacies, not just providing lower enrollee cost-sharing. (Part D plans that offer a CMS-defined standard benefit may not create preferred networks. About 2% of Part D enrollees are in standard benefit plans.)

Economic Significance

During the past several years, there has been a steady increase in the number of Part D plans offering preferred pharmacy networks (see **Figure 2**). In 2015, more than 86% Medicare Part D PDPs offer preferred networks, compared to 15% of PDPs in 2010. (More than 27% of MA-PDs have preferred networks in 2015, compared to 5% in 2010.) According to the Medicare Payment Advisory Commission (MedPAC) about 30% of pharmacies in Part D plan networks, on average, were preferred in 2013.

Figure 2. Part D PDPs Offering Preferred Networks



Source: CMS 2015 Final Call Letter and Medicare Part D Plan Data.

As a condition for joining a preferred network, a pharmacy may receive lower reimbursement from plan sponsors, such as smaller drug dispensing fees. In return, preferred pharmacies have the potential to gain a larger volume of drug sales and the ability to sell other merchandise and services to plan enrollees who come through their doors (or use a mail-order pharmacy option). Many large pharmacy chains and retailers participate in preferred networks including CVS, Walgreens, Rite Aid, and Walmart.

Some Part D plans reduce co-payments for less expensive brand-name and generic drugs at preferred locations. But enrollees may face similar co-insurance for expensive drugs at both preferred and non-preferred pharmacies. (Part D plans may charge enrollees up to 33% of the price of so-called specialty drugs that cost $600 per month or more.) Under Part D rules, cost-sharing is reduced for enrollees who reach a set level of annual out-of-pocket spending: $4,700 for 2015. After that point the enrollee is in the catastrophic phase of the benefit and is charged the greater of 5% co-insurance or a $2.65 co-payment for generic and multi-source drugs or a $6.60 co-payment for other drugs.

Key Issues

CMS has acted to ensure that beneficiaries understand preferred network pricing and that sponsors comply with program rules. In 2012, CMS altered its Medicare Part D Plan Finder tool to help enrollees identify differences in cost sharing at preferred and non-preferred pharmacies. (See www.medicare.gov/find-a-plan/questions/home.aspx.) In April 2013 CMS released a study of preferred pharmacy networks, based on 2012 PDP data. The study found while drug prices were generally lower in preferred networks, about 11% of Part D enrollees were in plans in which preferred pharmacies had higher average drug prices than non-preferred pharmacies. CMS said the data indicated that some plans might be increasing federal Part D costs, which could violate regulations.

In January 2014, CMS proposed rules that would have allowed plan sponsors to offer plans with preferred cost sharing (meaning lower-cost sharing for Part D covered drugs at certain network pharmacies) only if (1) any willing pharmacy able to meet a sponsor's pricing was allowed to participate, and (2) the preferred networks had both lower cost sharing and "consistently lower negotiated prices," meaning lower negotiated prices on all covered drugs.

The proposed regulations were opposed by many insurers on the basis that they could make it more difficult to negotiate price concessions, could make it harder to maintain quality standards within preferred pharmacies, and could lead to higher beneficiary costs. The FTC in a March 2014 letter to CMS said the proposed rules threatened the effectiveness of selective contracting with pharmacies as a tool for reducing costs. Independent pharmacies said the proposal would increase competition within the Part D program. In March 2014 CMS said it planned to drop the changes and did not include preferred pharmacy changes when it published final Part D rules in May 2014.

In December 2014 CMS released a study of beneficiary access to preferred pharmacies. CMS found that, on average, beneficiaries in most rural and suburban areas had convenient access to a preferred pharmacy, but for those in urban settings access was "substantially below" Part D standards. According to CMS, 54% of preferred networks did not meet the requirement that 90% of urban beneficiaries have access to a retail pharmacy within two miles of their home. In suburban areas, 13% of networks missed the requirement that 90% of enrollees have access within five miles. In rural areas, 5% of preferred networks missed the requirement that 70% of enrollees have access within 15 miles.

More Information

For more information see CRS Report R40611, *Medicare Part D Prescription Drug Benefit Medicare Part D Prescription Benefit*.

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