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Medicare Preferred Pharmacy Networks

Overview

The Issue: Private insurers that participate 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 have been 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 Part D rules.

Current Status: In January 2014, CMS 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 that doing so could hamper market competition. For the 2016 plan year, CMS worked with Part D plans to improve geographic access to preferred pharmacies, and it required plans with low access to add a special disclaimer to their marketing materials. During the 114th Congress, lawmakers have introduced legislation to require that preferred pharmacy plans have an adequate number of retail locations, with a focus on medically underserved areas.

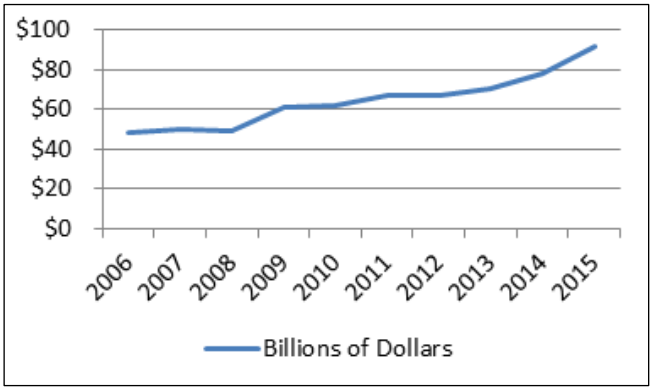
Preferred Pharmacy Networks

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 plans (PDPs) that offer only drug coverage or through 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 2015 *Medicare Trustees Report*, total Part D expenditures in 2014 were approximately $78 billion (see **Figure 1**). Total Part D spending has been lower than was 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 such as 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 plan enrollees may still use non-preferred pharmacies in their plan's network, but they would 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 above set Part D limits.

Figure 1. Annual Medicare Part D Spending



Source: *Medicare Trustees Report*, 2015.

Notes: Figures are in nominal dollars. 2015 figures are projected, the rest are actual.

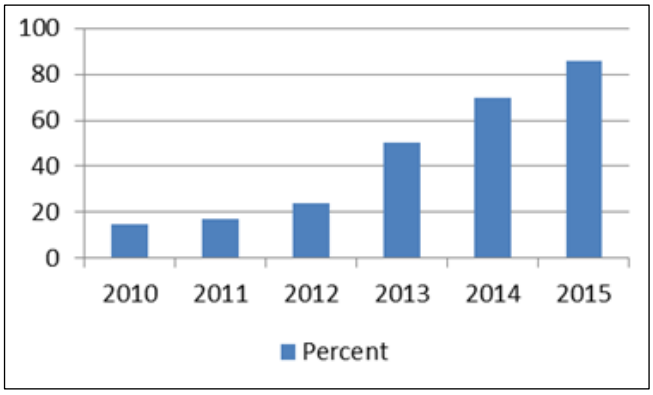
CMS rules also specify that the difference in enrollee costs between preferred and non-preferred pharmacies cannot be set at a level that discourages Medicare beneficiaries in

certain locations, such as inner cities or rural areas, from enrolling in that Part D plan. 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 what constitutes increased plan payments but has said that sponsors should be negotiating lower 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, the number of Part D plans offering preferred pharmacy networks has steadily increased (see **Figure 2**). In 2015, 87% of Medicare Part D PDPs offered preferred networks, compared to 15% of PDPs in 2010. (More than 27% of MA-PDs had 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 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 have lower premiums and reduced co-payments for less expensive brand-name and generic drugs at preferred locations. But enrollees may face similar coinsurance for expensive drugs at both preferred and non-preferred pharmacies. (For example, Part D plans may charge enrollees up to 33% of the price of so-called specialty drugs, which 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: $4,850 for 2016. After that point, the enrollee is in the catastrophic phase of the benefit and is charged the greater of 5% coinsurance or a $2.95 co-payment for generic and multisource drugs and a $7.40 co-payment for other drugs.

Key Issues

CMS has acted to ensure that beneficiaries understand preferred network cost sharing and 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 that although 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 payments, 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 the regulations could make it more difficult to negotiate price concessions, make it harder to maintain quality standards within preferred pharmacies, and 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. CMS did not include preferred pharmacy changes when it published final Part D rules in May 2014.

In April 2015, CMS released a final report on beneficiary access to preferred pharmacies. CMS found that, on average, beneficiaries in most rural and suburban areas had relatively robust geographic access to a preferred pharmacy, but beneficiaries in urban settings had more limited access or, in some cases, no access. CMS announced that it would work with Part D plans to improve geographic access to preferred pharmacies for the 2016 plan year, including requiring underperforming plans to disclose their lower access in marketing materials. In February 2016, CMS said preferred pharmacy access had improved dramatically, with 89 plans identified as geographic "outliers" required to carry marketing disclaimers. By comparison, 175 plans did not provide sufficient geographic access in 2014.

More Information

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

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