

Press Release

Details for: **MEDICARE CLARIFIES 'NEGOTIATED PRICES' UNDER PART D**

For Immediate Release: Tuesday, January 06, 2009

Contact: CMS Office of Public Affairs
202-690-6145

MEDICARE CLARIFIES 'NEGOTIATED PRICES' UNDER PART D BENEFICIARIES TO PAY LOWER COSTS AT THE PHARMACY COUNTER. RULE WILL BRING GREATER TRANSPARENCY TO DRUG PRICE REPORTING

Beginning in 2010, individuals enrolled in Medicare's prescription drug benefit will pay lower prices at the pharmacy counter under a final rule announced today by the Centers for Medicare & Medicaid Services (CMS). For beneficiaries with high overall drug expenditures, the change will slow their movement toward the initial coverage limit.

The rule revises Medicare's definition of negotiated prices by requiring drug plan sponsors under Part D to use the amount paid to a pharmacy as the basis for determining cost sharing for beneficiaries and for reporting a plan's drug costs to CMS. The negotiated prices are the costs for prescription drugs agreed upon through direct negotiation between the Part D sponsor or an intermediary contracting organization, such as a pharmacy benefit manager (PBM), and the pharmaceutical manufacturer. PBMs are third party administrators that process and pay prescription drug claims for prescription drug plans. The change is effective Jan. 1, 2010.

CMS currently allows Part D sponsors that contract with a PBM to report to the CMS the amount paid to the PBM (the lock-in price) or the amount the PBM paid to the pharmacy (the pass-through price). Under the lock-in approach, a Part D plan agrees to pay a PBM a set rate for a particular drug. The PBM then negotiates with pharmacies to obtain the lowest possible price for the drug, which often is lower than the amount the PBM receives from the plan.

Under the new rule, plans may continue to use the lock-in model with their PBMs, but they must report to CMS the price actually paid to the pharmacy as the negotiated price. Any difference between the price paid by the plan to the PBM and the price paid by the PBM to the pharmacy must be reported as an administrative cost. This requirement helps ensure that sponsors' administrative costs are not included in the drug costs used to determine

how much the beneficiary will pay, as well as reinsurance and risk corridor payments made by CMS. This will also create a uniform definition of drug costs for all Part D sponsors.

“For patients whose plan used the lock-in model, this regulation will reduce what they pay at the pharmacy counter because their copayment will no longer be based on a higher negotiated price,” said CMS Acting Administrator Kerry Weems. “The current lock-in approach also moves beneficiaries through the Part D benefit more quickly, bringing them to the ‘coverage gap’ sooner than under the pass-through pricing model.

“Part D plan sponsors will also benefit from the change. Making prices more transparent will help plans negotiate lower prices and administrative fees as they will be fully aware of how the amounts they are paying PBMs compare to the actual prices that PBMs are paying pharmacies,” said Weems.

The May 16, 2008 proposed rule also proposed similar revisions and additions to the definition of negotiated prices under the Retiree Drug Subsidy (RDS) program. The final rule does not finalize the changes proposed for RDS, but invites comments on several policy options.

The regulation also:

- Specifies that all new enrollees in special needs plans must be members of the special needs population that the plan is designed to serve;
- Permits CMS to impose a civil money penalty on plans of up to \$25,000 for each enrollee who has been adversely affected, or has a substantial likelihood of being adversely affected, when CMS determines that a contract has been violated;
- Codifies earlier guidance to plan sponsors about using best available evidence to determine an enrollee’s eligibility for extra help through the Part D Low Income Subsidy program. The change will help protect low-income beneficiaries from unnecessary copayments at their pharmacy counters.
- Clarifies that beneficiaries enrolled in Part C, or Medicare Advantage, and Part D plans who elect to have their premiums withheld from their Social Security payments may not be double-billed for premiums and specifies the process for retroactive collection of premiums; and
- Requires Medicare Medical Savings Account plans to report cost and quality information to beneficiaries as is currently done by similar private sector health savings accounts/high deductible health plans.

The rule may be viewed at <http://www.federalregister.gov/inspection.aspx#special>. It will be published in the Federal Register on Jan. 12, 2009.

#####