DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTERS FOR MEDICARE & MEDICAID SERVICES
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FACT SHEET

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Improving Successful Programs: The CMS Medicare Advantage and Part D Prescription Drug Benefit Proposed Rule

Since they were created, the Medicare Advantage and Part D prescription drug programs have been highly successful, with premiums holding below projections, quality ratings increasing, and enrollment numbers rising rapidly. The Affordable Care Act took many steps to further improve these programs, most notably closing the Part D coverage gap, or "donut hole," by 2020. Our goal is to continue improving these programs while keeping costs down, reducing fraud and abuse, and fostering competition. In January, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule (4159-P) with 72 provisions aimed at protecting beneficiaries, reducing costs, increasing transparency, ensuring plans' compliance with program rules, and improving quality. It also gives CMS new tools to combat fraud, waste and abuse in Part D. And, it would simplify choices and make benefits more meaningful for enrollees. In total, the proposed rule would save $1.3 billion over the five years from 2015 to 2019 if finalized. This is a proposed rule and we are committed to closely reviewing comments as part of our effort to work with all stakeholders to improve and strengthen these programs for beneficiaries.

Proposed Formulary Changes in Part D

A Historical Perspective. Beginning in 2006, Medicare Part D gave beneficiaries prescription drug coverage for the first time, allowing them to choose from a range of private plans to find the drug formulary that best fits their needs and budget. Formularies include more than 100 categories and classes of prescription drugs. To ensure a smooth transition to this new coverage for millions of Medicare beneficiaries, CMS required all Part D plans to include on their formularies nearly all drugs in six unique drug classes—antineoplastics, anticonvulsants, antiretrovirals, antipsychotics, antidepressants, and immunosuppressants.

Updating the Program. An evaluation of the nearly ten years of experience that CMS now has with Part D, has raised concerns that the existing policy could facilitate overutilization of some drugs in the protected classes, increasing costs without improving care for beneficiaries. As a result, CMS has proposed a new way to determine which, if any, unique classes need to have nearly all drugs on all formularies. If finalized, the new criteria would remove some types of drugs from the unique status, but beneficiaries would continue to have access to each class of drugs. And, this proposal would allow plans to begin intervening in cases of inappropriate utilization that could be harmful to Medicare beneficiaries.

Protecting Beneficiaries. CMS currently has numerous protections in place to protect beneficiary access to needed prescription medicines, including allowing beneficiaries to change plans, to receive transition supplies while they submit a formulary exception request, or to discuss switching to another medication with their physician if their current drug is being removed from a formulary, but they would like to keep their plan. CMS would also continue to exercise vigorous review of all drug formularies, and beneficiaries would maintain access to the proven Part D coverage determination process.

Our top priority is to ensure that Medicare beneficiaries are able to receive the prescription drug they need, when they need it. It is also our goal to reduce costs for beneficiaries and increase competition. As such, we are anxious to receive and review public comment on this provision to help ensure we strike the right balance.

Other Important Proposals to Reduce Fraud and Improve Quality

Preventing Prescription Drug Abuse. This proposal gives CMS new tools to address the serious and growing nationwide prescription drug epidemic. One proposal would require prescribers of Part D drugs to enroll in Medicare for their prescriptions to be covered under Part D, which helps CMS ensure that drugs are prescribed only by qualified licensed individuals. Another would give CMS the authority to remove a provider from Medicare for abusive prescribing practices and patterns. If finalized, this change would address a problem recently identified by the HHS Office of the Inspector General that some prescribers were participating in "pill mill" schemes that facilitate abuse and diversion of controlled substances. These anti-fraud efforts, which have been hailed by Senators Coburn (R-Okla.) and Carper (D-Del.), follow a Government Accountability Office recommendation that CMS improve its efforts to curb fraud and abuse in the Medicare Part D program.

Improving Payment Accuracy. The proposed regulation also would implement the Affordable Care Act requirement that Medicare Advantage and Part D plans report and return identified Medicare overpayments.

Ensuring Fair and Transparent Drug Prices. Preferred pharmacy networks can offer savings for beneficiaries, but that doesn't always happen. CMS has found that, in some cases, preferred networks end up increasing costs for taxpayers and beneficiaries. Instead of passing on lower costs available through economies of scale or steeper discounts, some plans actually charge higher negotiated prices. If finalized, the CMS proposal would require all price concessions from pharmacies to be reflected in negotiated prices. This transparency would allow beneficiaries to find the best deal for them and ensure they actually benefit from lower costs if they used preferred pharmacies. And plans would not be allowed to incentivize use of selected pharmacies (including those affiliated with or owned by the plan) if the pharmacy charges higher rates than their competitors.

Improving Preferred Pharmacy Network Access. This proposal would give beneficiaries access to a wider network and a wider choice of pharmacies by allowing all pharmacies, including small community pharmacies, to have the opportunity to participate as a preferred pharmacy, as long as they are willing to agree to a plan's terms and conditions. If finalized, the pricing and preferred network policies would

increase transparency, promote competition and help beneficiaries have increased access to preferred pharmacies with low prices.

Providing More Meaningful Plan Choices for Consumers. The Affordable Care Act has dramatically reduced the Part D coverage gap. As a result, the differences among plan offerings have also diminished. The CMS proposal is intended to encourage sponsors to focus on developing innovative plan designs that have broad beneficiary appeal. If finalized, it would allow companies to offer no more than two standalone Part D plans in a service area. Our proposal is designed to spread risk more evenly, save taxpayer money, and make it easier for beneficiaries to choose a plan that best meets their needs.

Expanding Prevention and Health Improvement Incentives. If finalized, this proposal would expand incentive programs that encourage participation in activities that promote improved health, efficient use of health care resources and prevent injuries and illness.

Interpretation of Non-Interference Provision. This proposal affirms existing agency practice to promote market competition in the establishment of plan formularies, drug prices and pharmacy networks. This is the same interpretation of the non-interference provision we have been operating under since the inception of the Part D program.