PCMA

Putting into Appropriate Context the Growth of Pharmacy DIR

Medicare Part D Direct and Indirect Remuneration (DIR) has grown in aggregate since the advent of the program. Indeed, pharmacy DIR was an innovation of Medicare Part D plans, which introduced pharmacy performance measures into the Part D program. Plans today use performance-based pharmacy network arrangements (also called preferred cost-sharing pharmacy networks) to encourage higher quality and contain costs, based on beneficiary preferences.

Beneficiaries prefer plans with preferred pharmacy networks, and these arrangements save money for all participants.

- **The Centers for Medicare & Medicaid Services (CMS) require that drug prices and cost sharing at preferred pharmacies be lower.** Preferred pharmacy networks lead to lower drug costs for enrollees and taxpayers.[i] One study estimated preferred networks create a single-year reduction in federal Medicare spending of $870 million.[ii]
- **Preferred pharmacy networks have grown in popularity among Part D enrollees since 2012.** CMS writes that "performance-based payment arrangements with pharmacies became increasingly prevalent" starting in 2012. The growth in aggregate DIR payments tracks with the growth in the use of these arrangements. *Drug Channels* estimates that in 2020, 95% of stand-alone Part D plans will use preferred pharmacy networks—up from just 7% in 2011.[iii]
- **Premiums are lower for Part D plans with preferred pharmacy networks.** Part D plans that use preferred networks have on average lower premiums than those that don't: basic Prescription Drug Plans (PDPs) had premiums that were 17% lower, while enhanced PDPs had premiums that were 57% lower.[iv]
    - **Beneficiaries continue to select plans with preferred networks.** For plan year 2020, 92% of Part D enrollees chose PDPs with preferred pharmacy networks—an increase from 88% in 2019.[v]
    - In a survey, 85% of seniors reported satisfaction with their preferred network PDP, and nearly 80% said they would be disappointed if their plan was eliminated.[vi]
    - Eliminating preferred networks could raise premiums by $63 per beneficiary per year.[vii]

Independent pharmacy participation has remained consistent. Independent pharmacies generally participate in preferred networks through their powerful pharmacy services administrative organizations (PSAOs). As of 2019, all but one major PSAO chose to participate in preferred networks.[viii] **Between 2010 and 2019, the number of independent pharmacies nationwide increased by more than 2,600 (a 13% increase).**

The definition of "fees" and "price concessions" changed in 2015.

- A CMS rule change implemented for 2015 expanded the kinds of pharmacy payments that are characterized as price concessions rather than fees.[ix] CMS's statements in the preambles to their 2019 and 2020 rules should have accounted for the effect of their own previous rule changes on the dollars associated with price concessions.
- While reported price concessions have grown since 2014, this growth was due at least in part to this rule change, not an underlying increase in amounts paid by pharmacies.[x]

- Pharmacy DIR is part of the overall national strategy to transition to value-based health care**.** It also reflects a nominal portion—2.6%—of total Part D plan payments to pharmacies in 2017, which is well within a reasonable at-risk amount for pay-for-performance strategies.[xi]

PBM tools, including network management, keep Part D spending growth in check.

- The 2019 Medicare Trustees Report found that manufacturer and pharmacy rebates are "a factor that has significantly slowed Part D spending growth."[xii]
- The Health and Human Services Office of Inspector General also found that rebates helped keep spending growth low in Part D.[xiii]
- The U.S. Government Accountability Office (GAO) confirmed PBMs play an important role "negotiating drug rebates and other price concessions," of which 99.6% are passed from the PBMs to the Part D plans to "help offset the growth in drug costs, helping control premiums for beneficiaries."[xiv]
- GAO also found that "rebates and other price concessions reduce the cost of the Part D program to beneficiaries and the federal government. … This downward pressure on premiums is one reason that premiums remained relatively unchanged between 2010 and 2015, according to CMS, even though total gross Part D drug costs grew approximately 12% per year in that period."[xv]

Ending or limiting the ability of PBMs to negotiate performance-based agreements would threaten the financial success of the Part D program. Based upon a previous CMS impact analysis, removal of pharmacy DIR could add between $20.7 and $25.8 billion in Part D costs over 10 years, which may represent a 25.5% increase in added costs for seniors in the form of higher premiums.[xvi]

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