Part D sponsor and its network pharmacy, the sponsor will: (1) Recoup 5 percent of its total Part D-related payments to the pharmacy at the end of the contract year for the pharmacy's failure to meet performance standards; (2) recoup no payments for average performance; or (3) provide a bonus equal to 1 percent of total payments to the pharmacy for high performance. For a drug that the sponsor has agreed to pay the pharmacy $100 at the point of sale, the pharmacy's final reimbursement under this arrangement would be: (1) $95 for poor performance; (2) $100 for average performance; or (3) $101 for high performance. However, under all performance scenarios, the negotiated price reported to CMS on the PDE at the point of sale for this drug would be $95, or the lowest reimbursement possible under the arrangement. Thus, if a plan enrollee were required to pay 25 percent coinsurance for this drug, then the enrollee's costs under all scenarios would be 25 percent of $95, or $23.75, which is less than the $25 the enrollee would pay today (when the negotiated price is likely to be reported as $100). Any difference between the reported negotiated price and the pharmacy's final reimbursement for this drug would be reported as DIR at the end of the coverage year. The sponsor would report $0 as DIR under the poor performance scenario ($95 minus $95), − $5 as DIR under the average performance scenario ($95 minus $100), and − $6 as DIR under the high performance scenario ($95 minus $101), for every covered claim for this drug purchased at this pharmacy.

(4) Additional Considerations

As with the policy approach that we described previously for moving manufacturer rebates to the point of sale, we would leverage existing reporting mechanisms to confirm that sponsors are appropriately applying pharmacy price concessions at the point of sale, as we do with other cost data required to be reported. Specifically, we would likely use the estimated rebates at point-of-sale field on the PDE record to also collect point-of-sale pharmacy price concessions information, and fields on the Summary and Detailed DIR Reports to collect final pharmacy price concession information at the plan and NDC levels. Differences between the amounts applied at the point of sale and amounts actually received, therefore, would become apparent when comparing the data collected through those means at the end of the coverage year.

Finally, as noted previously, the negotiated price is also the basis by which manufacturer liability for discounts in the coverage gap determined. Under section 1860D–14A(g)(6) of the Act, the definition of negotiated price used for coverage gap discounts is based on the regulatory definition of the negotiated price in the version of § 423.100 that was in effect as of the passage of the PPACA. As discussed previously, this definition of negotiated price only references the price concessions that the Part D sponsor has elected to pass through at the point of sale. As such, we are uncertain as to whether we would have the authority to require sponsors include pharmacy price concessions in the negotiated price for purposes of determining manufacturer coverage gap discounts. We intend to consider this issue further and will address it in any future rulemaking regarding the requirements for determining the negotiated price that is available at the point of sale.

(5) Impacts for Applying Pharmacy Price Concessions at the Point of Sale

Requiring that all pharmacy price concessions that sponsors and PBMs receive be used to lower the price at the point of sale, as we described earlier, would affect beneficiary, government, and manufacturer costs largely in the same manner as discussed previously in regards to moving manufacturer rebates to the point of sale. The difference is in the magnitude of the impacts given that sponsors and PBMs receive significantly higher sums of manufacturer rebates than of pharmacy price concessions. The following table summarizes the 10-year impacts we have modeled for moving all pharmacy price concessions to the point of sale: [54]

TABLE 11—2019–2028 POINT-OF-SALE PHARMACY PRICE CONCESSIONS IMPACTS

	Total (billions)	Per member-per month	Percent change
Beneficiary Costs	−$10.4	−$16.09	−1
Cost-Sharing	−16.1	−24.89	−3
Premium	5.7	8.79	2
Government Costs	16.6	25.65	1
Direct Subsidy	33.5	51.89	13
Reinsurance	−8.8	−13.74	−1
LI Cost-Sharing Subsidy	−9.9	−15.23	−3
LI Premium Subsidy	1.8	2.73	2
Manufacturer Gap Discount	−5.0	−7.69	−3

Moreover, while not accounted for when modeling these impacts, we seek comment on whether requiring that all pharmacy price concessions be included in the negotiated price, as we have described, would also lead to prices and Part D bids and premiums being more accurately comparable and reflective of relative plan efficiencies, with no unfair competitive advantage accruing to one sponsor over another based on a technical difference in how costs are reported. We are further interested in comments on whether this outcome could make the Part D market more competitive and efficient.

B. Improving the CMS Customer Experience

1. Restoration of the Medicare Advantage Open Enrollment Period (§§ 422.60, 422.62, 422.68, 423.38 and 423.40)

Section 4001 of the Balanced Budget Act of 1997 (BBA), added section

[54] Assumptions: (1) For purposes of calculating impacts only, we assume that pharmacy price concession will equal about 3 percent of allowable Part D costs projected for each year modeled, and that the concession amounts are perfectly substituted with the point-of-sale discount in all phases of the Part D benefit, including the coverage gap phase.

(2) Used 2016 distribution of costs by benefit phase to form assumptions.

(3) Assumed no other behavioral changes by sponsors, beneficiaries, or others.