Senate Finance Markup November 2023

Section 201. Assuring Pharmacy Access and Choice for Medicare Beneficiaries

Summary

- Modifies current Part D AWP language to clarify that a pharmacy that can meet the standard contract terms and condition under the plan can participate as a ***network*** pharmacy.
- Requires such terms and conditions be reasonable and relevant to standards established by the Secretary.
- Creates a new designation – "essential retail pharmacies" – requiring that PDPs with preferred pharmacies in their network contract with at least 80% of the "essential retail pharmacies" that are "independent community pharmacies" in their service area, as well as 50% of "essential retail pharmacies" that are not "independent community pharmacies," to include these pharmacies in the preferred network.
- Sets a minimum reimbursement rate for "essential retail pharmacies" that are "independent community pharmacies" at now lower than either the average NADAC for such drug for retail community pharmacies or, if not available, the NADAC for non-retail pharmacies. If NADAC is not available, the minimum reimbursement will be WAC.
- Defines an "essential retail pharmacy" as a retail pharmacy that: (1) is not an affiliate of a PBM or PDP sponsor; (2) is located in a MUA; and (3) is designated as an "essential retail pharmacy" by the Secretary.
- Requires PDP sponsors to report all affiliate pharmacies to the Secretary.
- Defines PBM and Affiliate.

TPs

- Reduces competition in the pharmacy market which will ultimately raise costs for Medicare beneficiaries, as well as drug costs.
- Standardizes all pharmacy performance metrics, which will mean that PBMs lose the ability to drive quality and innovation with their network pharmacies.
- Adds administrative burdens that will increase Part D program costs.

Section 202. Ensuring Accurate Payments to Pharmacies under Medicaid.

Summary

- Requires a survey of pharmacy AAC in Medicaid to inform sufficient pharmacy reimbursement rates. Requires updates to the survey no less than monthly and requires differentiation by pharmacy type.
- Prohibits states from using pricing information for non-retail pharmacies to develop or inform rates for retail community pharmacies.

TPs

- This is aligned with the current direction of CMS and does not need to be written into statute.
- Given the tight budget constraints states are facing, they may need the flexibility to select reimbursement models that work for their unique circumstances. Allowing this to be resolved through

CMS would provide states with an opportunity to provide valuable feedback and result in a more favorable outcome.

Section 203. Protecting Seniors from Excessive Cost Sharing for Certain Medicines.

Summary

- Beginning January 1, 2028, requires coinsurance be tied to the net, rather than gross, cost of a drug for "discount eligible drugs" which are drugs published on a list by the secretary. Such drugs have price concessions equal to or greater than 50% of gross costs of the drug and fall into one of 6 delineated USP categories (anti-inflammatories, bronchodilators, respiratory tract agents, anticoagulants, and cardiovascular agents). Also requires that cost-sharing for a covered Part D drug not exceed the negotiated price for such drug, net of all price concessions.

TPs

- In the context of current IRA implementation efforts, namely the Medicare Prescription Payment Plan – otherwise known as "smoothing," this may be unworkable. The complexity of adhering to the complex estimates here, ensuring actuarial soundness in compliance with Part D statutory requirements, and the new OOP maximum would create an operational challenge that could be insurmountable.
- Limits value based arrangements due to the provision to stay within a certain percentage range of an expected discount.

Section 204. Requirements for PDP Sponsors of Prescription Drug Plans and Medicare Advantage Organizations offering MA-PD plans that use Formularies under Part D of the Medicare Program.

Summary

- Beginning January 1, 2026, requires Part D formularies include at least one "high-discount biosimilar" if such formulary includes the reference biologic. The "high-discount biosimilar" must be placed on a different tier with lower cost sharing than the reference product and without utilization management policies that are more restrictive than what is applied to the reference product.
- Also beginning January 1, 2026, requires Part D formularies to include at least one "high discount biosimilar" if the formulary includes at least one "lower discount biosimilar" for a reference biologic. The "high discount biosimilar" must be placed on a different tier with lower cost sharing than every "lower discount biosimilar" and have less restrictive utilization management policies than what are applied to any "lower discount biosimilar."
- Requires HHS to annually publish a list of "high discount biosimilars" with WAC information.
- Defines a "high discount biosimilar" as a Part D biosimilar product with an average WAC at least 45% lower than the average WAC of the reference product.
- Defines a "lower discount biosimilar" as a Part D biosimilar product that is not a high discount biosimilar.

TPs

- Mandating formulary placement and inclusion reduces leverage to negotiate prices, resulting in higher overall costs, increased premiums for beneficiaries, and a windfall for drug companies.