



NOV 17 2010

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: Stuart Wright */S/*
Deputy Inspector General
for Evaluation and Inspections

SUBJECT: Memorandum Report: *Medicare Part D Pharmacy Discounts for 2008*,
OEI-02-10-00120

This memorandum report provides information about how sponsors negotiate discounts with pharmacies, how these discounts differ among brand-name and generic drugs, and whether sponsors are passing these discounts on to beneficiaries and the Government. Prior to this review, little information was available about pharmacy discounts. This information is critical for the Part D program because these discounts directly affect the amount that beneficiaries and the Government pay for Part D drugs.

We found that for all six sponsors we reviewed, pharmacy benefit managers (PBM) negotiated lower drug prices with pharmacies in exchange for the pharmacies being in the sponsors' networks. We also found that the pharmacy discounts for brand-name drugs were based on average wholesale prices, whereas the discounts for generic drugs were based on prices established by PBMs. Finally, we found that for five of the six sponsors, pharmacy discounts were not always passed on to beneficiaries and the Government. These results provide valuable information about how PBMs negotiate with pharmacies for lower Part D drug prices and about the pricing methods sponsors use to pay for these drugs. These results further highlight the importance of sponsors ensuring that they are receiving the pharmacy discounts they negotiated and that they are passing these discounts on to beneficiaries and the Government.

BACKGROUND

The Medicare Prescription Drug Benefit

The Medicare prescription drug program, known as Medicare Part D, provides an optional drug benefit to Medicare beneficiaries.¹ The Centers for Medicare & Medicaid Services (CMS) contracts with private insurance companies, known as Part D sponsors, to provide the drug benefit to beneficiaries who choose to enroll in the program.

Under Medicare Part D, sponsors may offer stand-alone prescription drug plans or they may offer prescription drug coverage as part of a managed care plan. At a minimum, Part D sponsors are required to offer a basic prescription drug benefit that is either the standard prescription drug benefit or is “actuarially equivalent” to the standard benefit.² Most beneficiaries are responsible for certain costs, which may include a monthly premium, an annual deductible, and coinsurance or copayments. However, low-income beneficiaries are eligible to receive assistance to pay some or all of these costs.³

Pharmacy Discounts

CMS requires that Part D sponsors develop a network of pharmacies to dispense drugs to beneficiaries enrolled in their plans.⁴ Sponsors generally contract with third-party entities, known as PBMs, to develop their pharmacy networks.⁵ CMS requires these pharmacy networks to be geographically diverse and to include different types of pharmacies, such as retail pharmacies and long-term care pharmacies.⁶

Sponsors also contract with PBMs to negotiate discounts with pharmacies. These pharmacy discounts affect the prices that beneficiaries and the Government pay for Part D drugs. In addition to negotiating lower drug prices with network pharmacies, PBMs also negotiate dispensing fees, which are payments provided to pharmacies for each drug dispensed.

It is important to note that pharmacy discounts are distinct from drug manufacturer rebates. Discounts negotiated with pharmacies are typically reflected in the price that the beneficiary pays at the pharmacy, whereas rebates are typically lump-sum payments made by drug manufacturers to sponsors. Drug manufacturers provide rebates to sponsors when they encourage beneficiaries to use certain drugs.

¹ The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173.

² 42 U.S.C. § 1395w-102, 42 CFR §§ 423.104(d) and (e). “Actuarially equivalent” means that the plan’s benefits must be of a dollar value equivalent to that of the standard benefit.

³ 42 CFR §§ 423.780 and 423.782.

⁴ 42 U.S.C. § 1395w-104(b)(1), 42 CFR § 423.120(a).

⁵ PBMs can provide a number of services to sponsors, including processing prescription drug claims, contracting with pharmacies, and managing formularies. Sponsors may also perform these services themselves.

⁶ Long-term care pharmacies provide specialized services, such as a comprehensive inventory of drugs commonly used in long-term care settings, specialized packaging, 7-day-a-week delivery, and emergency medications.

Payment to Pharmacies for Part D drugs

PBMs pay the pharmacies for drugs on behalf of the sponsors, and the sponsors later reimburse the PBMs for those drugs. The amount that the sponsor pays the PBM varies depending upon the pricing approach. Sponsors may contract with the PBM using what is known as “lock-in pricing” or “pass-through pricing.”

When lock-in pricing is used, the sponsor pays the PBM a set amount for its drugs. The PBM then negotiates with pharmacies for the best possible price, which may vary from the price the sponsor agrees to pay the PBM. If the PBM negotiates a lower price for a drug, then the PBM keeps the difference between the price the sponsor agreed to pay and the amount that the PBM actually pays the pharmacy. Conversely, when pass-through pricing is used, the sponsor reimburses the PBM the same amount that the PBM pays the pharmacy. The pass-through price is often lower than the lock-in price.⁷

METHODOLOGY

This memorandum report describes pharmacy discounts in the 2008 plan year. It is based on a review of contracts from six selected sponsors and their PBMs and structured interviews with officials from these six selected sponsors and their PBMs.

We selected a purposive sample of six Part D sponsors based on the number of beneficiaries enrolled in their plans and the PBMs they contracted with to get a variety of sponsors and PBMs for our review.⁸ Each of the six sponsors contracted with at least one PBM. These six sponsors represented more than 25 percent of all Part D beneficiaries in 2008. These are the same six sponsors that we reviewed in a forthcoming report entitled *Concerns With Rebates in the Medicare Part D Program*.⁹

Review of Contracts

For each of these 6 sponsors, we selected a purposive sample of 10 contracts that the PBM had with network pharmacies. To select these contracts, we first requested a list from each sponsor of all of the contracts it or its PBM had with pharmacies in 2008. From these lists, we selected 10 contracts from each sponsor. We selected a mix of contracts that covered retail and long-term care pharmacies as well as chain and independent pharmacies. In total, we received and reviewed 60 contracts. We reviewed these contracts for information about the nature and extent of pharmacy discounts and any associated dispensing fees.

⁷ The lock-in price includes a “risk premium” which the sponsor pays to the PBM to mitigate market risk and shield the Part D sponsor from price variability between pharmacies. 74 Fed. Reg. 1494, 1505 (Jan. 12, 2009). Beginning January 1, 2010, CMS required Part D sponsors to use the price received by the pharmacy to calculate beneficiary cost sharing and total drug costs. 74 Fed. Reg. 1506, 1544 (Jan. 12, 2009).

⁸ These six sponsors were selected from a universe of 258 Part D sponsors.

⁹ Office of Inspector General, *Concerns With Rebates in the Medicare Part D Program*, OEI-02-08-00500, forthcoming.

We also requested and reviewed all of the contracts that the six selected sponsors had with PBMs in 2008.¹⁰ We reviewed these contracts to determine the nature of the contractual relationships between the sponsors and their PBMs and how discounts were passed on to beneficiaries and the Government.

Structured Interviews

We conducted structured in-person or telephone interviews with officials from each of the six selected sponsors. We interviewed these officials to gain a better understanding of their pharmacy networks and discounts and their contractual relationships with PBMs. We requested that representatives from the PBM also be included in the interviews. In some cases, the representatives from the PBMs requested that we speak to them without the sponsors present because of the confidential nature of the information.

Our questions focused on how discounts were negotiated with pharmacies, the size of their pharmacy networks, the nature and extent of pharmacy discounts, and any associated dispensing fees. We also asked questions about the contractual relationships between the sponsors and their PBMs. For some questions, such as how discounts were negotiated with pharmacies, PBMs answered on behalf of the sponsors. Our questions focused on the 2008 plan year. We conducted these interviews between December 2008 and April 2009.

Limitations

The information in this memorandum report is from six selected sponsors and is not generalizable to all sponsors. In addition, because of the proprietary nature of the data on discounts, we presented general information and did not include specific data for the individual sponsors.

Standards

This study was conducted in accordance with the *Quality Standards for Inspections* approved by the Council of the Inspectors General on Integrity and Efficiency.

RESULTS

For All Six Sponsors, PBMs Negotiated Lower Drug Prices With Pharmacies in Exchange for the Pharmacies Being in the Sponsors' Networks

Each of the six sponsors we reviewed relied on PBMs to negotiate drug prices with pharmacies. These negotiations resulted in pharmacies charging lower drug prices for Part D beneficiaries than the prices they would charge their cash-paying customers. Pharmacies generally accepted these lower prices because participating in sponsors' networks increased the number of beneficiaries who used their pharmacies. Each of the 6 sponsors reported that their pharmacy network consisted of at least 55,000 pharmacies; 1 sponsor had more than 63,000 network pharmacies.

¹⁰ In total, the six sponsors had nine contracts with PBMs. Two of the sponsors had contracts with more than one PBM.

The PBMs for the six selected sponsors reported that they prepare standard contracts for various types of pharmacies, such as retail pharmacies and long-term care pharmacies. These contracts dictated the discounts that pharmacies had to accept in order to be part of the sponsor's network. Several PBMs reported that it was rare for pharmacies to participate in their networks if the pharmacies refused to accept the discounts in these standard contracts. However, in some cases, the PBM was willing to negotiate smaller discounts if, for example, the PBM needed a particular pharmacy to ensure sufficient geographic coverage in the pharmacy network.¹¹

For All Six Sponsors, Pharmacy Discounts for Brand-Name Drugs Were Based on Average Wholesale Prices and Varied by the Length of Supply, Pharmacy Type, and Geographic Location

For brand-name drugs, PBMs negotiated discounts based upon a fixed percentage that is subtracted from the drug's average wholesale price (AWP).¹² In the contracts we reviewed, this percentage is applied to all brand-name Part D drugs and varied by several factors, including the length of the supply, the pharmacy type, and geographic location.

Notably, in the contracts we reviewed, different discounts were often provided to retail pharmacies for an extended supply of drugs, such as a 3-month supply, versus a short-term supply of drugs.¹³ When this occurred, the discounts for an extended supply were greater and generally ranged from 18 percent to 22 percent of AWP. This compares to 15 percent to 17 percent of AWP for a short-term supply of drugs. In addition, these contracts often established higher dispensing fees for an extended supply of drugs. The average dispensing fee for an extended supply was \$2.20, compared to an average of \$1.90 for a short-term supply.

In a number of contracts, the pharmacy was given a separate option to participate in the sponsor's network for providing extended supplies of drugs. In these cases, the discounts for providing extended supplies were high—for example, 23 percent of AWP—and there was often no dispensing fees provided to the pharmacy. Only 9 of the 16 pharmacies that were offered this option chose to participate in the sponsors' extended supply network.

Further, discounts for drugs dispensed by long-term care pharmacies were generally smaller than those for drugs dispensed by retail pharmacies. In the contracts we reviewed, the discounts for drugs dispensed by long-term care pharmacies generally ranged from 12 percent to 14 percent, compared to 15 percent to 17 percent for retail pharmacies. In addition, long-term care pharmacies generally received higher dispensing fees. For example, in one contract we

¹¹ Sponsors must include enough pharmacies in their network to ensure that all beneficiaries have convenient access. 42 CFR § 423.120.

¹² The contracts also specified that PBMs would not pay the pharmacies more than the prices that they charge their cash-paying customers. As one contract noted, "AWP does not represent a true wholesale price, but rather is a fluctuating benchmark." Therefore, it is possible for the discounted prices to exceed the standard prices paid by cash-paying customers. This provision of the contract, commonly called a usual and customary provision, ensures that the PBM pays the lesser of the cash price or the discount based on AWP.

¹³ The length of supply could be either a short-term supply or an extended supply. The number of days included in a short-term supply was generally 1 month or less. An extended supply was generally more than 1 month and up to 3 months.

reviewed, long-term care pharmacies received dispensing fees that were twice as much as the dispensing fees provided to retail pharmacies.

Discounts also sometimes differed for certain geographic locations. For example, five of the six selected sponsors reported that their discounts were less substantial in certain areas, such as Alaska, Hawaii, the U.S. Virgin Islands, and Puerto Rico. One contract we reviewed for a pharmacy in Alaska set the discount at 5 percent of AWP. This contract also included a dispensing fee of almost \$8. One sponsor noted that these pharmacies often have higher costs because of their remote locations.

For All Six Sponsors, Pharmacy Discounts for Generic Drugs Were Based on Prices Established by PBMs and Were Often Accompanied by Higher Dispensing Fees and Benchmarks To Encourage Generic Drug Use

Pharmacy discounts for generic drugs were negotiated differently than the discounts for brand-name drugs. For each of the six selected sponsors, the PBM developed a list of generic drugs—known as the Maximum Allowable Cost (MAC) list—which established a maximum amount that the sponsor will pay for each drug on this list.¹⁴

Several PBMs noted that prices on their MAC lists change frequently, sometimes on a weekly or even a daily basis. PBMs also noted that pharmacies were not routinely provided access to the MAC lists. Most PBMs in our review provided their MAC lists (or a portion of their MAC list) to pharmacies only under limited circumstances, and one PBM would not share its MAC list under any circumstances. The pharmacies agreed to accept the prices on the MAC list without knowing what these prices were until they submitted their claims.

Further, in the contracts we reviewed, PBMs often established larger dispensing fees for generic drugs to encourage generic drug use. These fees were an average of 30 cents higher than the dispensing fees for brand-name drugs. Several of the contracts also allowed for additional payments to be made to the pharmacy if the pharmacy achieved certain levels of generic drug use among its Part D beneficiaries.

In addition, several sponsors' contracts included benchmarks that must be met by their PBMs. These benchmarks—which are often called generic effective rates—required the PBM to provide a minimum average discount among its network pharmacies for generic drugs. For example, one contract specified that average generic drug prices not exceed the AWP less 62 percent. If the discounts negotiated by the PBM did not meet this benchmark, the PBM had to reimburse the sponsor the difference. These benchmarks help to encourage generic drug use among Part D beneficiaries.

¹⁴ For generic drugs not included on the MAC list, the contracts specified that the sponsor would receive a discount based on the drug's AWP. The contracts also specified that the sponsor would not pay the pharmacy more than the prices they charge their cash-paying customers.

For Five of the Six Sponsors, Pharmacy Discounts Were Not Always Passed on to Beneficiaries and the Government

Five of the six selected sponsors reported using lock-in pricing for at least some drugs in 2008. In some cases, sponsors used lock-in pricing for some plans and not for others. In other cases, they used lock-in pricing only for certain types of drugs, such as generic drugs.

When lock-in pricing was used, beneficiaries and the Government did not always receive the full benefit of the pharmacy discounts negotiated by PBMs. This was because the lock-in prices—rather than the actual pharmacy discounts negotiated by PBMs—were used to calculate both the beneficiaries’ and the Government’s share of the drug costs. Because lock-in prices tend to be higher than the actual pharmacy discounts negotiated by PBMs, this pricing method increases the overall cost of these drugs for beneficiaries and the Government.¹⁵

Beginning in 2010, CMS required sponsors to provide the full benefit of pharmacy discounts to beneficiaries and the Government. CMS issued new regulations requiring sponsors that use lock-in pricing to include all pharmacy discounts negotiated by PBMs to calculate beneficiaries’ and the Government’s share of the drug costs.¹⁶

CONCLUSION

Pharmacy discounts are an effective tool for lowering the costs of Part D drugs. We found that for all six sponsors we reviewed, PBMs negotiated lower drug prices with pharmacies in exchange for the pharmacies being in the sponsors’ networks. We also found that the pharmacy discounts for brand-name drugs were based on average wholesale prices, whereas the discounts for generic drugs were based on prices established by PBMs. Finally, we found that for five of the six sponsors, pharmacy discounts were not always passed on to beneficiaries and the Government. These results provide valuable information about how PBMs negotiate with pharmacies for lower Part D drug prices and about the pricing methods sponsors use to pay for these drugs. These results further highlight the importance of sponsors ensuring that they are receiving the pharmacy discounts they negotiated and that they are passing these discounts on to beneficiaries and the Government.

This report is being issued directly in final form because it contains no recommendations. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number OEI-02-10-00120 in all correspondence.

¹⁵ 74 Fed. Reg. 1505, 1544 (Jan. 12, 2009).

¹⁶ 42 CFR § 423.100, 74 Fed. Reg. 1544 (Jan. 12, 2009). See also 74 Fed. Reg. 1505–1506 (Jan. 12, 2009).