PCMA
PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION

Medicare Part D Benefit: A Primer

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Medicare Part D

- PBM participation in Part D is robust.
- PCMA members are 5 of the 10 national PDPs, and one regional PDP.
  - Premiums and formulary coverage offered are competitive with other plans.
- PBMs will be contracting and supporting MA-PDPs to provide the drug benefit.
- Assisting employer clients determine the right way to participate (subsidy, wrap around, direct sponsor).
  - Most employers are taking the subsidy in 2006—2007 decisions need to made early in the year.

Medicare Part D

- PCMA Primary focus- Let the market work
- PBM business model fits into the current cost conscious environment.
- The only organization in the drug supply chain that strives to *reduce* the costs of drugs.
- Over-regulation and mandates limit this effectiveness.
  - E.g. Requiring coverage of drugs on formulary, limiting mail order.
  - Numerous guidance, program memorandum, Q+As, etc.

Medicare Part D

- PCMA issues-Direct negotiation/Price setting
- Results in cost shift to the private sector
- Limited choice models do not work
- Government does not have a good track record in setting prices for drugs.
  - E.g. Medicaid, Medicare Part B oncology
  - Not nimble enough to stay on top of a constantly changing market place.

Part D – Consumer groups

- Traditional view- increase access without regard to cost implications.
- Renewed focus- increased competition among manufacturers and generic utilization.
- PCMA is working on efforts to increase generic utilization and maintain competition.

Part D – Marketing

- PCMA member companies are putting out millions of dollars worth of advertising.

- Marketing Guidelines- Mutual concerns with AARP about pharmacists steering beneficiaries pharmacy run plans.
  - Possibility of cherry picking healthier beneficiaries
  - Not the best plan choice for that senior
  - Pharmacist is a trusted health care provider and should not be in the role of marketing.

Part D - Transparency

- Beneficiaries have access to drug prices before enrolling in a PDP and also once they are enrolled, available at www.medicare.gov, each plan's website and via each plan's 1-800 numbers.

- PDP sponsors must disclose to CMS aggregated pricing and drug specific pricing data including:
  - discounts
  - rebates
  - price concessions from manufacturers

- All pricing information is subject to CMS audit.

Electronic Prescribing

- Awaiting a final rule for the foundation standard.
- The need for one uniform set of standards as opposed to 51 individual standards.
- PBMs are the leaders-
  - The RxHUB- a network developed by the three independent PBMs.
  - The only system that provides comprehensive formulary information and medication history.
  - Both standards are in process of getting ANSI accredited through NCPDP.
- Proposed rule- E-prescribing safe harbors under the Anti-Kickback Statute and an exception under the Stark law.
  - Generally positive-allows for providing “non monetary remuneration” as an incentive for providers to use e-prescribing.
  - Initial read- Must comply and be compatible with e-prescribing standards to qualify for the safe harbor. (the provider and the technology itself).
  - Although no value limit was proposed on the technology to qualify, there may be a cap at some point.

Third Party Liability

- By law, Medicaid is the payer of last resort. As part of reconciliation, changes are being made by the House and Senate to ensure Medicaid remains the payer of last resort.

- PCMA supports this effort however, the current language fails to achieve the objective:
  - language makes PBM liable for 3rd party claims recovery,
  - PBMs do not take insurance risk and are not financially liable for Medicaid claims,
  - PBM clients are legally responsible for Medicaid claims payment,
  - contractual duty to the client to process claims does not translate into payment liability.

- Employers share our concern with the current language and also raise issue with the obligation of third parties to provide states with an overly broad and burdensome amount of coverage eligibility and claims data, noting the different requirements for the 51 different jurisdictions.

Third Party Liability (con't.)

- States currently engage in "pay and chase" where the state initially pays the claim then bills the third party insurer when applicable.
- This is not cost-effective.
- Incentives should be created for states to develop stronger programs to identify, at the point of care, when a Medicaid recipient has other health insurance (and when Medicaid should be the secondary payer).

Biodefense

- PCMA strongly opposes any language that would decrease generic drug utilization thus increasing overall health care costs, such as;
  - orphan drug market exclusivity
  - broad definition of countermeasure

- PCMA does support solutions to preparedness such as minimizing product liability, providing tax credit for research and manufacturing, guaranteed purchasing and government funding.


SQUARE PEG.
ROUND HOLE.
Some things just aren't supposed to go together. Like fighting bioterrorism and extending drug company monopolies.
America needs new drugs to guard against a bio-terror attack, and we support liability protections, guaranteed purchasing and direct government assistance so miracle medicines will be available when disaster strikes.
But extending drug company monopolies will burden the nation with even higher prescription drug costs—with absolutely no guarantee that a breakthrough counter-measure will be developed. That's why market exclusivity provisions have no place in the fight to shield millions from the threat of disease and bio-terror.
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