May 5, 2006

Q: Can a plan establish a generic-use incentive program permitting zero (or reduced) copays on first generic fills if an enrollee agrees to use the generic rather than the brand-name version of a medication?

A: Some plans have expressed interest in establishing a program whereby an enrollee would be offered an incentive in the form of a copay reduction if he or she switches from a brand-name to the generic version of a medication. The goal of such incentive programs is to minimize drug spend and maximize compliance with plan formularies.

We believe that the statute and our regulations permit plans to offer this type of incentive program as part of their benefit design. Plans could establish such a benefit design through the creation of a cost-sharing sub-tier that allows a beneficiary to have a zero (or reduced) copay for the first fill of a generic drug only. Although in 2006 our PBP layout would not allow plans to enter this level of detail, this will be possible as part of plans' PDP uploads for the 2007 plan year.

Q: Can plans establish cost-sharing tiers within their formularies for drugs that treat specific diseases?

A: We understand that some plans – and, in particular, special needs plans geared toward beneficiaries with certain conditions – may want to create cost-sharing tiers that lower cost-sharing for drugs that treat certain conditions in order to improve medication therapy compliance. As provided in the statute and our regulations, plans may not establish benefit designs that discourage enrollment by a class of beneficiaries. If a plan establishes such a cost-sharing tier on its formulary, and the drugs on that tier are generally low-cost or do not have a significant actuarial impact in terms of raising cost-sharing for drugs used to treat other conditions, this aspect of its benefit design should not raise any concerns about discrimination. If, however, a plan's proposed formulary structure lowers cost-sharing for drugs that treat certain conditions by raising cost-sharing for drugs used to treat other conditions, CMS shall reject the formulary on the grounds that it discourages enrollment of some beneficiaries such as those with the same diagnosis but who have multiple comorbidities that may require more expensive medications.

Q. What should an individual do if he or she is able to obtain a better price on a covered Part D drug at the point of sale than the negotiated price charged by his or her Part D plan if he/she is in the coverage gap? Will that lower amount at the point of sale count toward the enrollee's TrOOP balance?

A: Although we expect it to happen rarely, an individual may be able to obtain a lower price at a network pharmacy than that which his or her plan charges in the coverage gap (the plan's negotiated price). This may be possible if the pharmacy is offering a "special" price or other discount for all customers.

If an enrollee is able to receive a better cash price for a covered Part D drug (for example, by using a discount card) at a network pharmacy during the coverage gap, he or she may purchase that covered Part D drug at the point of sale without using his or her Part D benefit or a supplemental payer's coverage. The enrollee's purchase price for the discounted drug will count toward total drug spend under his or her Part D benefit and TrOOP balance provided the Part D plan finds out about it. This means that the enrollee will have to submit the appropriate documentation to his or her plan in order to have the amount count toward his or her total drug spend and TrOOP balances. Plans must accommodate the receipt of such information directly from enrollees and adjust total drug spend and TrOOP balances accordingly.