Medicare Part D Preferred Networks
Frequently Asked Questions

Q: What is a Part D preferred pharmacy network?
CMS regulations currently permit Medicare Part D plans to establish networks of “preferred pharmacies.” These networks generally are limited to a smaller number of select pharmacies and/or pharmacy chains. These pharmacies provide lower co-pays to beneficiaries in exchange for lower reimbursement to the pharmacy. In theory, pharmacies participating in the preferred network benefit by increased volume from preferred network patients. However, we encourage pharmacies to closely consider the terms and conditions in every contract presented to them to determine whether it makes sense to participate as a provider.

Q: How did preferred pharmacy networks come into existence?
Preferred pharmacy networks have been contemplated within the Medicare Part D program since 2006. However, it wasn’t until more recently that plans implemented preferred networks. In 2013, there were several large national Part D plans that featured preferred pharmacy networks, and the trend is continuing in 2014.

Q: What retail pharmacy access standards must plans meet in order to participate in the Medicare Part D program, and how do these standards apply to preferred networks?
The Medicare Modernization Act (MMA) includes requirements to assure that Medicare beneficiaries will have access to retail pharmacies close to their homes. To receive approval to participate as a Medicare Part D plan, a plan must meet the TRICARE access standards for retail pharmacies. This means that in an urban area, at least 90% of Medicare beneficiaries in the Part D service area, on average, must live within 2 miles of a retail pharmacy that is part of the plan’s network. In suburban areas, at least 90% of Medicare beneficiaries in the Part D service area, on average, must live within 5 miles of a retail pharmacy that is part of the plan’s network. And, in rural areas, at least 70% of Medicare beneficiaries in the Part D service area, on average, must live within 15 miles of a retail pharmacy that is part of the plan’s network. However, these standards only apply to the plan’s primary pharmacy network. Plans are not required to meet these same standards when establishing preferred pharmacy networks.

Q: Why don’t federal and state Any Willing Provider laws apply to preferred networks?
CMS interprets the MMA’s Any Willing Provider provision as not applying to nor prohibiting preferred pharmacy networks. As a result, plans may deny pharmacies from participating in a Part D plan’s preferred pharmacy network. Based on the current rules, this does not violate the Any Willing Provider provision because that provision does not require that all Part D plans give the same terms and conditions to all pharmacies for all networks. Part D plans with preferred networks still allow non-preferred pharmacies to participate in the plan, but not on the same terms and conditions. In other words, any pharmacy can still provide Part D drugs to patients in a plan with a preferred pharmacy network, but the reimbursement may be different and the cost-sharing may be different than for a patient that has his or her prescription filled at a preferred pharmacy. Lastly, state Any Willing Provider laws generally do not apply because the federal MMA supersedes state laws in most cases.

1 Currently plaintiffs in one case challenging the legality of preferred networks in the Medicare Part D program have filed a petition with the U.S. Supreme Court to revive its case that the Fifth Circuit previously dismissed on jurisdictional grounds.
Q: Is there a cost for pharmacies to participate in a preferred network?
In some cases, a PBM may charge a pharmacy a fee to be part of the preferred network. In most cases, the fee will be charged on a “per claim” basis for each claim submitted. NCPA encourages members to closely consider the terms and conditions in every contract presented to them, including those for preferred networks, to determine whether it makes economic sense to participate as a network provider. Ultimately, it is up to each individual pharmacy to make an independent business decision regarding such participation.

Q: What has been done to address the concerns of independent pharmacy owners regarding preferred networks in Medicare Part D?
For several years, NCPA has continued to raise concerns with CMS regarding preferred networks, including deceptive marketing tactics, beneficiary confusion when selecting plans, lack of continuity of care as patients may be forced to change plans yearly based on cost concerns, and compromised access as a result of preferred network plans. Members of Congress also continue to press CMS on oversight of preferred pharmacy networks. To date, more than 50 members of the House of Representatives and several Senators have asked CMS to answer the concerns and questions that they have been hearing from Medicare beneficiaries and small business owners in their states and congressional districts regarding Medicare Part D plans that feature preferred pharmacy networks. A sample of the questions which have been posed to the CMS Administrator include:

- How do you intend to decrease the hardship on Medicare beneficiaries and small business owners regarding these Part D networks?
- How do you plan to make sure that small pharmacies are guaranteed a chance to compete with large health plan and chain pharmacies and participate in these preferred network plans?
- How do you plan to make sure that these marketing tactics are changed so that patients know how far they might have to travel to get their prescriptions filled?

We appreciate the concern from Members of Congress who have posed these questions to CMS and NCPA is pleased to see that the Agency has begun to address these issues, such as making distinctions between preferred and non-preferred pharmacy locations clearer on Plan Finder and warning plans about misleading marketing practices.

Although CMS continues to allow preferred network plans, the agency has begun to address some of the concerns raised with the structure of these narrower networks. CMS has responded to inquiries from Members of Congress, and stated that while any willing provider provisions are not a requirement with respect to participation in a preferred pharmacy network, “a Part D sponsor may not establish a differential between cost-sharing at preferred versus non-preferred pharmacies that is so significant as to discourage enrollees in certain areas (rural areas or inner cities, for example) from enrolling in that Part D plan – even if it otherwise meets our retail access standards detailed. We would consider a pharmacy network that effectively limits access in portions of a Part D sponsor’s service areas in this manner to be discriminatory and disallowed.”

In addition, the in the 2014 Call Letter, the Agency further stated that it “strongly believe[s] that including any pharmacy that can meet the terms and conditions of the preferred arrangements in the sponsor’s preferred network is the best way to encourage price competition and lower costs in the Part D program. Doing so would also likely mitigate some beneficiary disruption and travel costs, especially in rural areas.”

Updated as of 10/8/2013