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CMS Announces Results of First Round of Drug Price Negotiations for Medicare Part D

The Centers for Medicare and Medicaid Services (CMS) has announced the negotiated prices for 10 drugs covered by Medicare Part D for 2026. This is the first time Medicare has negotiated prices pursuant to the authority granted by the Inflation Reduction Act of 2022.

The negotiated prices will apply only with respect to the Medicare Part D program, including Medicare Advantage plans that offer prescription drug coverage and standalone Part D plans.

Among the 10 drugs included in this initial cycle of negotiations are several well-known prescription drugs, including Jardiance, Stelara, Xarelto, and Eliquis. In most cases, the savings for Medicare beneficiaries will be significant. Of the drugs mentioned above, the savings from the 2023 list price will range from 56% for Eliquis to 66% for Jardiance. The discount for the diabetes drug Januvia will be 79%.

The negotiated drug prices will be effective beginning on January 1, 2026, and will remain in effect (subject to an annual inflation adjustment) for so long as the drug remains in the Medicare Drug Price Negotiation Program. Additionally, CMS will select 10 new drugs for the negotiation program for 2027.

RMD Regulations in Practice: What Employers Need to Know

In light of the release of the long-awaited final regulations on required minimum distributions ("RMDs") in July, this article focuses on the practical issues surrounding mandatory distributions that practitioners should know, as well as the effective date of the regulations.

Final RMD Regulations

On July 19, 2024, the Internal Revenue Service ("IRS") published its final RMD regulations, following the release of proposed regulations almost two and a half years prior. The final regulations largely reflect amendments made to the RMD rules in the Internal Revenue Code that were enacted by the SECURE Act of 2019 ("SECURE 1.0"), as well as some additional changes enacted by the SECURE 2.0 Act of 2022 ("SECURE 2.0"). A more complete explanation of the final RMD rules is available in Rewards Policy Insider 2024-16.

Key Distribution Rules for Plans

A key issue regarding the RMD rules is what plans are *permitted* to do with respect to distributions from participants' accounts versus what they are *required* to do.

The final regulations reflect the new required beginning date ("RBD") – which refers to the time when a retirement plan participant or IRA owner reaches a

certain age and therefore must begin taking distributions from their account – as updated by SECURE 2.0, which increased the RBD to age 75 from age 72. The increase in the RBD to age 75 reflects a statutory requirement that account owners must start taking RMDs by a certain age.

Plans still have the option to require participants to start taking distributions *earlier* than their RBD. However, a plan cannot allow participants to defer RMDs later than their RBD.

If employers decide they want to follow the new RMD regulations with respect to the increased RBD, they should know that the increase of the RBD from age 72 to age 75 occurs in two phases over the course of multiple years. For individuals who turn age 72 after 2022 and age 73 before 2033, the RBD is age 73. For individuals who turn age 74 after 2032, the RBD is age 75.

Must-Know Effective Dates

The final regulations apply for distributions made on or after January 1, 2025. Because the final regulations will apply in a matter of months, practitioners should begin the process of updating their systems to reflect the new RMD rules very soon. For the many plans that have been operating based on the proposed RMD regulations released in 2022, the good news is that the final RMD regulations generally retain the key provisions from the proposal, so updating their systems at this juncture should not require a massive overhaul.

For RMDs taken in years earlier than 2025, taxpayers must apply the prior RMD regulations (published in 2002 and 2004), taking into account a "reasonable, good faith interpretation" of the relevant amendments to the rules made by SECURE 1.0 and SECURE 2.0. Relying on the 2022 proposed regulations will satisfy this standard for SECURE 1.0 (note that SECURE 2.0 was enacted several months after the proposed regulations were published).

Appeals Court Rules that Health Insurer Not Required to Cover Autism Treatment under the MHPAEA

In an opinion released in early August, the Seventh Circuit Court of Appeals ruled that the Mental Health Parity and Addiction Equity Act ("MHPAEA") did not require a health insurer to cover speech therapy as a treatment for autism for a minor child. At the time relevant to the case, medical literature did not support speech therapy as a treatment for autism.

Background

In general, the MHPAEA prohibits health insurers and health plans that provide mental health or substance use disorder ("MH/SUD") benefits from imposing less favorable benefit limitations than they place on medical/surgical benefits.

The parents of a child who was diagnosed with autism asked their health insurer to cover certain therapies, including speech therapy and sensory-integration therapy, between 2017 and 2019. Upon review of medical literature available at the time, the insurer determined that evidence did not support speech therapy as treatment for autism for someone of the child's age and did not support sensory-integration therapy as an autism treatment at all.

The employer-sponsored plan in which the family was enrolled specifically covered only treatments that were "evidence-based," which is explicitly permitted in the MHPAEA regulations. As a result, the insurer declined to cover those therapies. (As a separate matter, development in medical literature led to the insurer beginning to cover these therapies for the child in 2020.)

Following an internal review and appeals process, the parents sued, arguing that the insurer violated the MHPAEA by not covering the treatments in 2017 through 2019, while it covered another benefit – chiropractic care for certain pediatric patients – which they alleged lacked scientific support. Therefore, the parents argued, the insurer applied the requirement that treatments be "evidenced-based" more strictly to mental health benefits than to medical benefits.

A Wisconsin district court sided with the defendant health insurer and dismissed the case.

Circuit Court Ruling

On appeal, the Seventh Circuit affirmed the district court's ruling in *Midthun-Hensen et al. v. Group Health Cooperative of South Central Wisconsin*. In its decision, the court agreed with the district court that the differences in coverage between the autism treatments and the chiropractic treatment merely reflected differences in the medical literature on which the insurer relied. The court highlighted that the pre-2020 denials of coverage for the autism treatments reflected how the underlying literature assessed and accounted for the effectiveness of the treatments at different ages, not how the insurer itself assessed the literature. Therefore, the insurer did not impermissibly impose less favorable limitations on MH/SUD benefits.

The court also pointed out that the MHPAEA requires that treatment limitations on MH/SUD benefits are no more restrictive than limitations applied to "substantially all" medical/surgical benefits covered by the plan. But here, the parents focused on a single kind of treatment (i.e., chiropractic care for children), rather than focusing on treatments as a whole.

This case serves as an important reminder of the parameters of the MHPAEA's requirements, particularly that employer-sponsored plans do not violate the MHPAEA simply by covering only "evidence-based" treatments. Note that this particular case, however, only applies to courts that fall within the Seventh Circuit, which covers courts in Illinois, Indiana, and Wisconsin.

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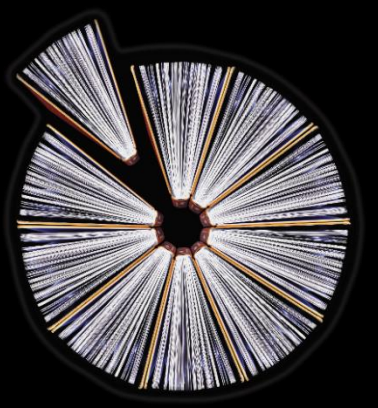

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