

# Medicare Prescription Drug Coverage



## AV Health Policy Brief

*Improving Medicare Parts B and D to lower  
spending for patients and taxpayers*

### THE ISSUE

Medicare Part B and Part D help beneficiaries pay for their prescription drug costs. Part B generally covers physician-administered drugs that patients receive in an outpatient setting, while Part D covers retail prescriptions that patients can pick up at a pharmacy.

Medicare Part B has seen significant growth in drug spending in recent years as new specialty products to treat conditions such as cancer or arthritis come to market. The methodology used by Part B to pay for these drugs can incentivize providers to prescribe higher-cost products. As a result, program costs increase for the taxpayer and many patients are forced to pay high coinsurance either out of pocket or via higher premiums for insurance purchased to supplement Medicare benefits. For example, Keytruda is the top selling drug in Medicare Part B. Spending on this drug came to \$3.5 billion in 2020 and the annual cost per beneficiary that used the drug was \$59,642 in 2020.<sup>i</sup> At that cost, a beneficiary that pays the 20% coinsurance would have out-of-pocket costs of almost \$11,928.

Medicare Part D, on the other hand, after also experiencing significant growth in spending in recent years, was reformed in late 2022 with the passage of the Inflation Reduction Act. These reforms overhauled the benefit's structure and, for both Medicare Part B and D, gave the Secretary of Health and Human Services the ability to negotiate prices for certain high-cost drugs and created a penalty that drug manufacturers will pay to Medicare if they increase their prices faster than inflation.

Despite these improvements, there are still refinements that can be made to the Medicare program that can help further contain prescription drug costs for patients and taxpayers.

### THE EVIDENCE

Spending on Part B drugs neared \$41 billion in 2020, which is nearly double the amount spent in 2012.<sup>ii</sup> Spending on all Part B drugs grew at nearly 11 percent a year from 2009 to 2020. Of that growth, over half was due to price increases of existing drugs, the adoption of new, higher-priced drugs, and shifts in the mix of drugs.<sup>iii</sup> Growth in Part B drug spending is particularly high because physician-administered products are often high-cost specialty drugs or biologics which typically face limited competition. The methodology Medicare uses to pay for these drugs exacerbates this problem. Medicare reimburses providers for most Part B drugs based on a drug's Average Sales Price (ASP), which is the price it is sold to providers including rebates and other price concessions, plus an add-on payment of 6 percent.<sup>iv</sup> Because the add-on payment is a percent of the drug's price, providers get paid more by prescribing higher cost medication.

Similarly, Medicare Part D spending has increased from \$73.7 to \$198.6 billion from 2009 to 2020, growing at an annual average rate of 9.4 percent.<sup>v</sup> Further, the average net prices of brand-name prescription drugs paid by Medicare Part D plans, which account for

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rebates, more than doubled over the last decade.<sup>vi,vii</sup> As mentioned, recent historic reforms to Medicare Part D, including Medicare negotiation, an inflation penalty, and changes to beneficiary cost-sharing, will provide some relief to beneficiaries at the pharmacy counter once they are fully implemented. Of note, beneficiary out-of-pocket costs have been capped at \$2,000 a year and out-of-pocket costs for insulin have been capped at \$35 a month. However, these reforms do not fully address the increasing prices new drugs are launched at. These so-called “launch prices” are climbing sharply, and from 2008 to 2021, launch prices for new drugs increased an average of 20% annually.<sup>viii</sup>

## THE SOLUTIONS

### ***Medicare Part B***

- Reduce or reform the ASP add-on payment for physician-administered drug reimbursement. This could be calculated either as a lower percentage add-on or as a flat add-on fee, eliminating potential incentives to prescribe higher-cost products.
- Allow physicians to form purchasing groups and negotiate their own formularies for physician administered drugs. This would mimic some of the cost-containment techniques already used in the Part D benefit and through private plans and would allow groups to leverage purchasing power and market forces to negotiate for lower prices, which could be particularly helpful to smaller community providers. It would be designed to ensure that the purchasing groups, and in turn the taxpayer, does not pay more than ASP for a physician administered drug.
- Require that Medicare use the same billing code for biosimilars and their reference biologic product. This would be like the way generic small molecule drugs are treated. Currently, biosimilars are reimbursed at their own ASP plus 8 percent of the reference biologic’s ASP, but this will sunset in 2027 when it will revert to 6 percent and again offer no difference in margin for the provider to administer a biosimilar. Absent further reform, there will continue to be weak incentive to use a biosimilar over the higher priced biologic.
- Require that Medicare use internal reference pricing or consolidated billing codes under which a single reference price for brand-name drugs that have similar health effects would be established based on the Part B drug payment rates of the products in the reference group. This would create incentives to lower prices relative to competitors.
- The Trump Administration introduced the International Price Index (IPI) Model, which benchmarks Medicare reimbursement for Part B drugs to an international reference price.<sup>ix</sup> Models like the IPI, which use international reference prices, are worth examining. They could reduce costs for beneficiaries and taxpayers significantly, while still ensuring access to critical medications.
- Require prescription drug, biological, and biosimilar manufacturers to exclude the value of coupons provided to privately insured individuals from each drug’s ASP.
- Implement an “uncertainty price” in Medicare Part B for medications approved via the accelerated approval pathway until confirmatory trials have been completed and prove clinical benefit. This price could be 76% of the ASP for the existing standard of care, corresponding to the federal ceiling price used by the Department of Veteran’s Affairs.<sup>x</sup>

### ***Medicare Part D***

- Grant Part D plans greater flexibility to manage the six protected classes, such as limiting the number of drugs covered in more competitive classes to at least 3 or 4 drugs per class. For six therapeutic classes known as protected classes, Medicare Part D plans are currently required to cover “all or substantially all” drugs. This requirement may reduce the plan’s ability to negotiate discounts for these drugs.
- Streamline the process for formulary changes, require greater justification for prescribing exceptions to established formularies, and permit plans to use selected tools to manage specialty drug benefits while maintaining appropriate access to needed medications.
- Remove generic cost-sharing for Low Income Subsidy (LIS) beneficiaries and increase or tier brand cost-sharing to lower premiums and out-of-pocket costs.

## ENDNOTES

- i** CMS Drug Spending Main Dashboard <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Information-on-Prescription-Drugs>
- ii** [MedPAC July 2022 Data Book](#) Section 10, Chart 10-1.
- iii** [MedPAC July 2022 Data Book](#) Section 10, Chart 10-2.
- iv** Explaining the Prescription Drug Provisions in the Inflation Reduction Act, KFF, published January 24, 2023, <https://www.kff.org/medicare/issue-brief/explaining-the-prescription-drug-provisions-in-the-inflation-reduction-act/>
- v** [MedPAC July 2022 Data Book](#) Chart 10-16.
- vi** Congressional Budget Office. "Prescription Drugs: Spending, Use and Prices." January 19, 2022. Retrieved from <https://www.cbo.gov/publication/57050>
- vii** MedPAC. "Initial findings from MedPAC's analysis of Part D data on drug rebates and discounts." April 7, 2022. Retrieved from <https://www.medpac.gov/wp-content/uploads/2021/10/MedPAC-DIR-data-slides-April-2022.pdf>.
- viii** Rome BN, Egilman AC, Kesselheim AS. Trends in Prescription Drug Launch Prices, 2008-2021. JAMA. 2022;327(21):2145–2147. <https://jamanetwork.com/journals/jama/fullarticle/2792986>
- xi** [International Pricing Index \(IPI\) Model | CMS Innovation Center](#)
- x** Frank RG, Emanuel EJ. Paying for Cancer Drugs That Prove Their Benefit. JAMA. 2021;326(16):1579–1580. <https://jamanetwork.com/journals/jama/article-abstract/2785217>