Medicare [Part B]

Health Policy Brief | A number of payment reforms could encourage the use of the most clinically appropriate product, regardless of price, or the use of lower-cost alternatives.

THE ISSUE

Medicare Part B, which covers physician-administered drugs, has seen significant growth in 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.

$30B

Spent on Medicare Part B drugs in 2016

10%

Medicare Part B spending growth for drugs in every year between 2009 and 2015

90%

The percentage of the top 10 drugs by spending in Medicare Part B that are high cost biologics

THE EVIDENCE

Spending on Part B drugs neared $30 billion in 2016, which is nearly double the amount spent in 2010.[1] The Medicare Payment Advisory Commission (MedPAC) noted that price is the largest factor contributing to the growth of Part B drug spending.[2] Spending on all Part B drugs grew at roughly 10 percent a year from 2009 to 2015. Of that growth, over half was due to price increases.

Growth in Part B drug spending is particularly high because physician-administered products are often high cost specialty drugs or biologics. Of the top 10 drugs by spending in Part B in 2016, nine were high cost biologics, which typically face limited competition.[3] 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 other payers including rebates and other price concessions, plus an add-on payment that is just over 4 percent.[4] Because the add-on payment is a percent of the drug's price, providers get paid more by prescribing higher cost medications.

THE SOLUTIONS

- Reduce or reform the ASP add-on payment for physician-administered drug reimbursement.[5] 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 similar to the way generic small molecule drugs are treated. Currently, biosimilars are reimbursed at their own ASP plus a percentage of the reference biologic's ASP. This provides no difference in margin for the administering provider and a weak incentive to use a biosimilar over the higher priced biologic.
- Improve ASP data reporting by requiring all manufacturers to report ASP data.
- Reduce the amount Part B pays for new single-source drugs from 106 percent of wholesale acquisition cost to 103 percent. CBO found that this would save $152 million over 10 years.[6]
- To help control price growth that is driving spending in the program, Congress should institute an inflationary rebate in part B. CBO has estimated that this type of penalty could cave $1.5 billion over 10 years.[7] This type of inflation penalty is used to control price growth in Medicaid and would reduce both the prices paid for Part B drugs and the associated beneficiary cost sharing.
- The Administration introduced the International Price Index (IPI) Model, which benchmarks Medicare reimbursement for Part B drugs to an international reference price.[8] 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.

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[1] http://www.medpac.gov/docs/default-source/data-book/jun18_databooksec10_sec.pdf?sfvrsn=0
[2] http://www.medpac.gov/docs/default-source/data-book/jun18_databooksec10_sec.pdf?sfvrsn=0
[3] The Laura and John Arnold Foundation's Analysis of CMS Part B spending file.
[4] https://www.cms.gov/sites/drupal/files/2018-10/10-25-2018%20CMS-5528-ANPRM.PDF
[5] http://www.medpac.gov/docs/default-source/reports/chapter-3-part-b-drug-payment-policy-issues-june-2015-report-.pdf
[6] https://www.cbo.gov/system/files/115th-congress-2017-2018/dataandtechnicalinformation/53906-medicare.pdf
[7] https://www.cbo.gov/system/files/115th-congress-2017-2018/dataandtechnicalinformation/53906-medicare.pdf
[8] https://innovation.cms.gov/initiatives/ipi-model/