



Research

Primer: Medicare Part B Drug Payment System

ANGELA BOOTH | JANUARY 21, 2015

The Medicare program provides health insurance coverage to individuals age 65 and older, as well as those with specified permanent disabilities. Coverage is available for a range of services, including inpatient care (Part A), physician services and outpatient care (Part B), and prescription drug services (Part D)—as well as an alternative, private plan (Medicare Advantage/Part C). For Medicare beneficiaries that receive coverage under traditional Medicare (Parts A, B and D), certain drugs are administered by a physician and/or their clinical staff and fall under Part B; while Part D covers drugs dispensed to patients by pharmacies. There are different reimbursement systems for the Part B physician-administered medications and those covered under Part D. The different reimbursement systems reflect the important differences in these products.

This primer explains the history of Part B prescription drug payment, the functionality of the average sale price (ASP) payment system, and the benefits of the current payment system.

BACKGROUND

Most drugs are covered under Part D, where patients normally obtain the medicine from a pharmacy and can take the medication at home. Medicare Part B covers a certain subset of drugs that treat chronic and/or severe illnesses, such as cancer and rheumatoid arthritis, which require much greater physician involvement than a normal prescription that patients obtain from a pharmacy. Part B drugs typically must be injected or infused in a physician's office or outpatient facility, and often require clinical monitoring.

Importantly, Part B drugs are not purchased by patients at retail pharmacies. Physicians purchase the drugs directly from manufacturers and drug distributors, and Medicare reimburses physicians for the cost of the drugs and the services utilized to administer them. In recent years, spending for Part B drugs has remained relatively stable, due to changes in the reimbursement methodology issued as part of the Medicare Modernization Act of 2003 (MMA).

FORMER PAYMENT POLICIES: AWP

Prior to the MMA, under the Balanced Budget Act (BBA) of 1997, Medicare reimbursed physicians at 95 percent of the average wholesale price (AWP) for each drug that physicians billed or the actual charge, whichever was lower.^[1] However, the BBA did not provide a clear definition, or uniform reporting requirements.

AWP is not an actual market price, but should be viewed as a suggested list price. Though Medicare reimbursement was set at 95 percent of AWP, most physicians were able to receive steeper discounts on Part B drugs and purchase these drugs significantly below the Medicare payment rate. The Government Accountability Office (GAO) published a report in 2001 that evaluated 35 drugs and found that for most Part B drugs, the average discount ranged from 13 percent to 34 percent below AWP. On the highest end of the spectrum two drugs had discounts of 65 and 86 percent.[2]

Under AWP-based payment, Part B drug spending continued to climb. From 1997 to 2003, Part B drug spending increased from \$2.8 billion to \$10.3 billion, an increase of 25 percent per year.[3] This increase was concerning for both the Centers for Medicare and Medicaid Services (CMS)—which pays for 80 percent of the cost—as well as for Medicare beneficiaries, who are responsible for the 20 percent copayment on Part B drugs.

CHANGES TO PART B PAYMENT: MOVING TO A MARKET-BASED ASP

The MMA fundamentally changed the way that Part B drugs are reimbursed by instituting the ASP methodology. It relies on market-based prices to set reimbursement rates. Congress set the Part B reimbursement at the ASP+6 percent. Under ASP, reimbursement for the drug was lowered to more closely resemble the actual cost of acquiring the drug, and the 6 percent add-on helps to cover the overhead costs associated with the drug and differences in acquisition costs.[4]

The ASP is defined as the volume weighted average manufacturer sales price net of all rebates, discounts, and other price concessions. Drug manufacturers that participate in the Medicaid Drug Rebate Program (MDRP) are required to submit ASP sales prices and volume to CMS quarterly for each drug. CMS then uses this data to calibrate the ASP rates in a subsequent quarter, with a 2-quarter lag (*i.e.*, Q1 sales are the basis for Q3 ASP payment rates).[5] This methodology makes the reimbursement for Part B drugs more market based since CMS is now paying for a drug based on the prices in the market, including discounts and rebates providers receive when purchasing the drugs.

Under ASP, spending growth has leveled out for Medicare Part B drugs. In the first year of the change in methodology (2005), Part B pharmaceutical spending declined 8 percent. Today, spending remains relatively stable increasing at an average of 4 percent each year. Though there is an increase in spending, the change from 25 percent increases seen under AWP shows the implementation of the ASP has been effective in controlling spending growth.[6]

Accounting for Additional Costs and 6 Percent

As mentioned above, physicians are reimbursed at ASP+6 percent. Providers are reimbursed for 100 percent of the average cost of the drug, and an additional 6 percent is given to account for extra costs.[7] These extra costs include a variety of requirements that go along with these complex drugs, such as additional expenses in the administration, mixing, and storage of certain drugs. The additional 6 percent also helps to cover differences in physicians' acquisition costs. Some physician offices may receive a steeper discount based on purchasing volume. Others, such as smaller, rural physician offices, may receive a smaller discount due to lower purchasing volumes. The 6 percent provides some allowance for differences in prices negotiation for the same drug by physicians practicing in different circumstances.

The 6 percent can also work to negate some other outside pressures that physicians may be facing. For

example, some beneficiaries may not be able to meet their 20 percent copayment, which then falls to the practice as debt. Another pressure faced by physicians purchasing Part B drugs is the 2-quarter lag time for ASP payment rates to reflect current prices. Further, physicians can also be reimbursed inaccurately due to prompt-pay discounting programs where discounts negotiated between the manufacturer and the drug distributor are included in the calculation of the ASP, but not passed down to physicians decreasing their margins for reimbursement.[8]

Recently, cuts instituted by the Budget Control Act of 2011 decreased Medicare reimbursement by two percent, impacting the thin margin available for cushion in Part B drug payments and reducing the ASP add-on from 6 to approximately 4 percent. All of these instances can compound and effectively decrease the additional reimbursement that is provided by the 6 percent add-on. This results in thinning or non-existent margins for physicians and their practices on Part B drugs.

Reviewing ASP

In November 2014, the Medicare Payment Advisory Commission (MedPAC) discussed an ongoing review of Medicare Part B drug payment methodology. MedPAC discussed whether physicians have an incentive to choose more expensive drugs under ASP in order to receive a higher add-on payment in cases where several drugs may be available to treat a certain condition. Therefore, the Commission is reviewing potential payment policy options including: changing the provider add-on percentage to a flat fee, setting the drug payment amount based on the average cost of multiple drugs that have similar clinical outcomes, developing payment bundles for drugs and services, and/or providing a flat fee for all Part B medication management to providers.[9]

CONCLUSION

As federal officials and policymakers review the effectiveness of the ASP methodology, the success of this payment system should be taken into consideration. The ASP methodology has stabilized spending growth for Part B drugs, and prevented the continued significant growth of Part B drug spending. The 6 percent add-on also strikes a careful balance that allows for physicians to continue participating in the program and patients continued access to care. Review of the ASP methodology should recognize the existing fragile balance between budgetary savings and sufficient provider reimbursement levels that ASP offers today.

[1] <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/HistPartBDrugPricingFiles/Overview.html>