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Medicare Part B Drug Reimbursement

Why Change A Market-Driven System That Works Well at Controlling Costs?

Douglas Holtz-Eakin & Han Zhong l October 26, 2011

The Joint Select Committee on Deficit Reduction must focus on mandatory spending programs to be successful. Unfortunately, proposals to alter Medicare Part B drug reimbursement place a successful program and the patients it supports at risk, and thus, are neither sound nor sustainable reform policies that support overall debt reduction.

Executive Summary

Deficit Reduction and Part B Drug Reimbursement

- The Joint Select Committee must focus on mandatory spending to be successful. However, proposals to change Part B reimbursement risk undermining a successful market driven program and fail to provide durable reform.

Changes Will Restrict Access to Cancer Patients

- Lowering reimbursement will likely create market disruptions by causing oncologist practices to close, thereby limiting Medicare access for seriously ill cancer patients.

Current ASP+6 Reimbursement is Working

- Growth in drug expenditures in Medicare Part B has been limited to 2-3 percent annually since ASP+6% was introduced, significantly below overall growth in spending in the Medicare program.

Proposed Changes Do Not Cover Physician Costs

- Physicians need to be reimbursed at ASP+6% to pay for shipping fees, handling supplies, as well as the cost of storage.
- Proposed changes in the current reimbursement will likely undermine the ability of physicians to cover their costs and as result will undermine patient access to care.

Understanding Drug Reimbursement in Medicare Part B

Medicare reimburses for prescription drugs in two settings. Outpatient prescription drugs are covered by Medicare Part D, while prescription drugs administered in a physician's office are paid for by Medicare Part B. The Part B drugs are delivered "incident to" physician services, meaning they require a physician's expertise to infuse or inject. Most commonly, these are cancer drugs used for chemotherapy and its related side effects or drugs to treat other grievous illnesses, and can be dangerous if the proper precautions are not taken in administering the drug.

Physician practices and hospitals typically purchase these drugs through wholesalers or directly from the drug manufacturer. Medicare Part B reimburses the physician for the drug based on its Average Sales Price (ASP) plus 6 percent ("ASP+6%").

An important aspect of the current reimbursement system is that it helps cover costs over and above those of the drugs and the patient office visit (which is reimbursed separately by Part B). Physicians also incur shipping fees, the cost of supplies used in handling and the overhead costs for storing these fragile products.

This method of reimbursement, designed to combat rapid increases in Part B drug spending, replaced the previous payment method based on average wholesale

Douglas Holtz-Eakin (dholtzeakin@americanactionnetwork.org) is the President of the American Action Forum.
Han Zhong (hzhong@americanactionforum.org) is a healthcare staff assistant at the American Action Forum.

price (AWP) in 2005. The switch to drug reimbursement based on ASP+6% has proven to be very successful. Medicare Part B expenditure on prescription drugs has grown at a much lower rate than other parts of Medicare.

Part B Drug Reimbursement Encourages Cost-Saving

The average sales price varies based on the net average sales price of a drug to all purchasers including volume discounts, generic substitution, prompt-pay discounts, cash discounts and rebates.[1] Thus, when any purchaser is sold a drug at a discounted price, the ASP will reflect this discount.[2] When physicians choose to purchase a drug for a cheaper price, they are rewarded by a greater margin of payment—a market-driven approach to cost control based on incentives to find the best price possible. Similarly, large hospital systems and smaller physician practices and hospitals that join Group Purchasing Organizations (GPOs) have stronger leverage for a volume-discounted price.

Oncologists and the Patients They Treat at Greatest Risk to Part B Drug Reimbursement Reduction

Medicare Part B drug reimbursements account for a significant amount of an oncologist's revenue compared to other specialists. As shown in Table 1, Part B drug reimbursements accounted for 74 percent of Medicare-covered services provided by an oncologist; this represented 70 percent of an oncologist's revenue from Medicare. Furthermore, a recent study in the *Journal of Clinical Oncology* found that "many [oncology] practices pay prices above ASP+6% reimbursement for key products" and concluded that the "economic strain combined with inadequate reimbursement limits patient access to care when practices are forced to turn away patients or go out of business." ASP reductions could force oncologists to turn away cancer patients or even close their doors if the practice is Medicare-dependent.[3]

Table 1: Part B drug reimbursement by volume and allowed charges among specialists (2005)

Specialist	Volume of Medicare services provided	Total Medicare allowed charges[a]
Medical Oncologist[b]	74%	70%
Rheumatologist	50%	46%
Urologist	31%	20%
Infectious Disease	8%	6%

a. Allowed charges are the services that Medicare is authorized to cover.

b. Medical oncologists include hematologists, hematologist/oncologist and medical oncologists.

Source: C. Hagan, Direct Research, analysis of Medicare physician-supplier procedure summary file, 2002-2005 from *MedPAC January 2007 Report to the Congress: Impact of Changes in Medicare Payments for Part B Drugs*.
http://www.medpac.gov/documents/Jan07_PartB_mandated_report.pdf

[1] With exceptions such as the Medicaid program's "best price" used in calculating Medicaid rebates, sales to Part D plans and many government programs that purchase drugs through statutory price controlled formulas.

[2] There is a two-quarter lag between drug sales and when the ASP reflects the sale of the drug. CMS deems this necessary to prevent unchecked price increases and also promotes faster utilization of generics. More frequent manufacturer price submissions would also increase administrative burdens.

[3] Favret, UB, Jordan, WM, Kirchof, MS, Neltner, ME and Chudzik DA. "An examination of oncology drug purchasing compared to average sales price. *J Clin Oncol* 26: 2008 (May 20 suppl; abstr 20500). http://www.asco.org/ascov2/Meetings/Abstracts?&vmview=abst_detail_view&confID=55&abstractID=30313.

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The Impact of Changes to Part B Drug Reimbursement

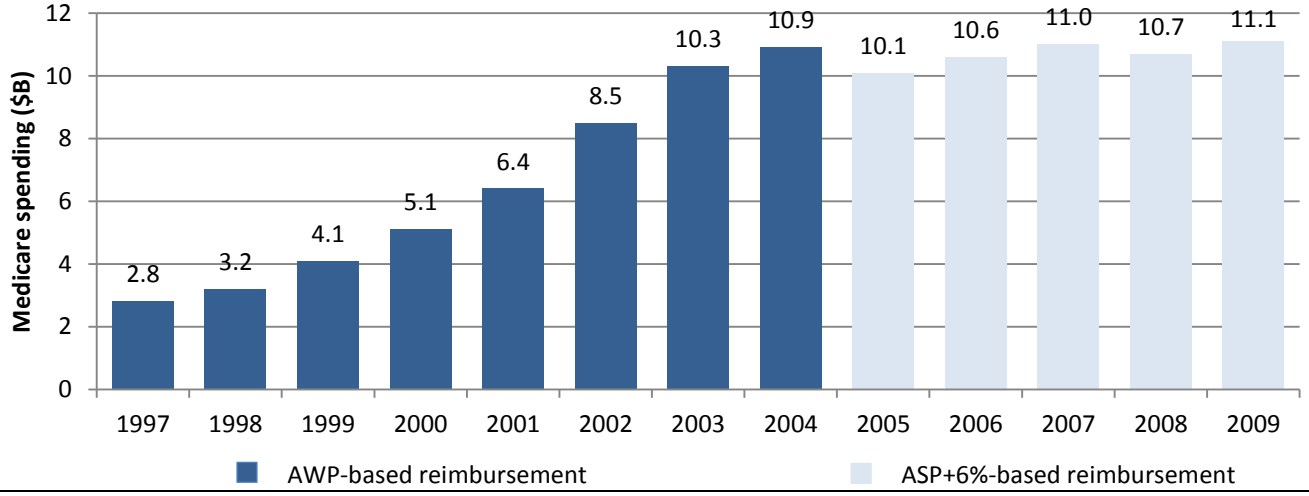
To achieve the objectives of the Joint Select Committee on Deficit Reduction, some have suggested changes to Part B drug reimbursement by shifting to ASP+3%. This change would save an estimated $3.2 billion over the next ten years, according to the House Ways and Means Committee Minority Staff. While perhaps attractive from a narrow budgetary perspective, such a change would threaten Medicare beneficiaries' access to care. Cutting payments to physicians in a program that works as intended will only create greater accessibility issues and lower quality of care.

Smaller physician practices would be especially at risk by the reduction in reimbursement to ASP+3% due to their reliance on GPOs to negotiate drug prices. GPOs charge administrative fees to generate revenue, causing the actual price physicians pay to be higher than the sale price to the GPO. Reducing the reimbursement rate would make it more difficult to afford such fees.

Why Change Something that Works?

In the first year it was introduced, the ASP+6% reimbursement policy reduced Part B drug spending by 7.3 percent and since then, spending has seen a limited average annual growth rate of 2.4 percent[4] (Figure 1). Compared to overall Medicare expenditure, which has grown at an average of 10.9 percent annually over the same period,[5] Part B drug reimbursement is on a much more affordable track. In conclusion, the Medicare reimbursement system for Part B drugs strikes the right balance between providing access to medicines for cancer and other illnesses while constraining costs in an efficient market-driven manner that allows both small providers in rural areas and large practices to provide ongoing care to Medicare beneficiaries.

Figure 1: Medicare spending for Part B drugs administered in physicians' offices or furnished by suppliers*



* Data include Part B-covered drugs administered in physicians' offices or furnished by suppliers (e.g. certain oral drugs and drugs used with durable medical equipment). Data do not include Part-B covered drugs furnished in hospital outpatient departments or dialysis facilities, which are reimbursed under different rates.

Source: ***MedPAC June 2011 Data Book. Health Care Spending and the Medicare Program*****.**
http://www.medpac.gov/documents/Jun11DataBookEntireReport.pdf.

[4] Author's calculations of data from 2005 to 2009 based on *MedPac Report to Congress June 2011*.
[5] Author's calculations of data from 2005 to 2009 based on *2011 Medicare Trustees Report*. https://www.cms.gov/reportstrustfunds/.

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