Medicare Financing and the Cost of Drugs: Part B

Introduction

Despite recent volatility, prescription drug costs and spending—including out-of-pocket costs for patients—are projected to rise significantly over the next several years.[1] Further, total government share of all U.S. retail prescription drug spending is expected to near 50 percent by 2026.[2] In recent years, drug manufacturers have dramatically increased prices even on decades-old drugs,[3] contributing to this unsustainable growth.

And Medicare, the federal health program spending the most on drugs—more than $185 billion in 2017 alone—is a significant part of this trend. Overall, Medicare is the second-largest government program, with costs within Medicare increasingly shifting toward drug spending.[4]

Understanding how the major programs that reimburse for drugs in Medicare work—known as Part B and D—as well as the possible policy solutions to address both programs' problems, is vital to engaging in any meaningful debate on how to address the rising prices of prescription drugs.

The following brief provides an overview of how Part B operates and impacts government and beneficiary spending and a summary of leading reform proposals. Part D is discussed in a companion brief *("Medicare Financing and the Cost of Drugs: Part D")*.

MEDICARE BASICS

Medicare provides coverage for individuals over the age of 65, some younger individuals living with disabilities, and patients with End-Stage Renal Disease. There are approximately 60 million people on Medicare.[5] Eight in ten beneficiaries also have private supplemental insurance to their Medicare coverage—largely through an employer or union retiree health plan or an individually purchased Medigap plan.[6] Despite most beneficiaries having supplemental insurance that may change how coverage is paid for, the Medicare program overall represents the most significant avenue of health insurance coverage for older Americans.

Medicare has four distinct programs that provide insurance coverage for different services: Parts A, B, C, and D. Prescription drug reimbursement in Part B and Part D are those most relevant to the discussion on drug pricing, with Part B being the focus of this brief.

Conversations over Medicare funding generally are often grounded in concerns that funding may eventually be exhausted.[7] This concern, however, is focused on Part A—

MEDICARE'S SERVICES

PART A
Referred to as the "hospital insurance" part of Medicare, Part A is best known as the program that provides coverage for certain in-patient care at hospitals and other similar settings.

PART B
Referred to as the "medical insurance" part of Medicare, Part B is best known as the program that provides coverage for certain doctors' services and outpatient care (including reimbursement for physician-administered drugs).

PART C
Also known as Medicare Advantage (MA), Part C is a group of private plans that provide Part A and Part B coverage as well as typically Part D coverage and sometimes additional coverage such as dental or vision.

PART D
Part D provides coverage for certain retail prescription drugs through individual private plans.

the part of Medicare that is funded by the "Hospital Insurance" trust fund, which is paid for through payroll taxes.[8] Part C is the Medicare Advantage program—private Medicare plans.[9] Parts B and D, however, are largely funded though general revenue, the majority of which comes from federal income taxes paid by individuals and payroll taxes paid by workers and employers, as well as beneficiary premiums.[10]

This means that Part B's long-term funding concerns are that both general revenues from federal income taxes and premiums must rise to cover increases in costs—for example, from increasing drug prices—in a way that directly harms individuals' personal finances and raises government spending concerns.

PART B: HOW IT IS PAID FOR & WHAT IT COVERS FOR PRESCRIPTION DRUGS

In 2017, $30.4 billion was spent on drugs under Part B.[11] While this figure still represents a relatively small share of overall Part B spending, it is a rapidly growing number and the driving factor in the increased spending being observed in Part B generally.[12] From 2013 to 2017, overall Part B spending grew at an average annual rate of 10 percent[13]—a growth over four times higher than the average rate of inflation over the same time period.[14]

Part B Drug Coverage

There is no formulary under Part B. Instead, Medicare sets parameters for the type of drugs covered under Part B and in what situations they will be covered.[15] Part B does not have a separate "drug plan," beneficiaries receive coverage for their medicines under the general umbrella of their Part B coverage.

Drugs covered under Part B are physician-administered, typically infusion or injectable drugs, and are provided in an outpatient setting, such as a doctor's office or an outpatient hospital department.

Importantly, the majority of drug spending under Part B is on drugs known as biologics, a rapidly growing area of medicine that includes some of the most expensive drugs on the market.[16] These medicines also lack a robust market for biosimilar alternatives—these are similar to the brand-name biologic drug but not structurally the same due to the complexity of forming these drugs, but they have the same effect as the "reference" biologic.

General Part B Financing & Beneficiary Cost-Sharing

Part B is paid for through the Supplemental Medicaid Insurance (SMI) Trust, of which approximately 27 percent is financed through beneficiary premiums, 71 percent financed through general revenues, and 2 percent financed by interest. Every year, general revenue and premium amounts are set to cover costs of the program, and they are expected to rise significantly in coming years.[17]

In recent years, overall spending in Part B has risen from 41 to 44 percent of all Medicare spending,[18] largely driven by spending on drugs. Some of the most expensive drugs are covered under Part B. Among the top ten drugs in terms of total Part B spending in 2017, all but one had spending of more than $1 billion, with several nearing $2 billion and the top drug exceeding that amount.[19] Nearly half of all Part B spending is on these ten drugs, despite the program covering nearly 600 medications.[20]

Every year, Part B's standard monthly premium is set by the Centers for Medicare and Medicaid Services (CMS). For 2019, it is $135.50 with an annual deductible of $185—both of these numbers having been increased from 2018.[21] In addition, beneficiaries pay a 20 percent coinsurance with no limit on out-of-pocket cost-sharing.[22] While some beneficiaries have supplemental insurance or other forms of cost assistance, this 20 percent coinsurance represent a significant expense for many beneficiaries.[23]

Part B Reimbursement & Supply Chain

Reimbursement for Part B covered drugs, given the uniform way in which drugs are covered under the program, is relatively straightforward. Providers, such as physicians and hospitals, are reimbursed 106 percent of the average sales price (ASP) of the drug—this system is commonly referred to as ASP+6 percent.[24] When ASP is not yet available for new medications, drugs are reimbursed at 106 percent of the wholesale acquisition cost (WAC), also known as the list price, which doesn't take into account any discounts and risks significant over payments.[25]

Under Part B, provider first buys and stores covered drugs and then later bills Medicare for reimbursement after the drug is administered, also referred to as the "buy and bill" system. The ASP amount that reimbursement is based on is a number reported by a manufacturer quarterly and represents the market price for the drug, inclusive of any rebates and discounts provided—all provided by the manufacturer itself. The 6 percent add-on is designed to take into account providers' handling costs for ordering and storing the drug as well as a buffer in the case of drug pricing variability.

This system may create an incentive for providers to choose the more expensive drug in order to increase their reimbursement amounts and, as a result, for manufacturers to keep prices high. Especially given that there is no formulary tools that could arguably be used to select lower-cost drugs and alternatives, this preference for high prices also disincentivizes competition among drug manufacturers broadly as a result.

One long-sought policy proposal that could address this disincentive in regard to biologics was somewhat recently addressed by the FDA. CMS requires biologics and biosimilars to use separate, distinct billing codes. Having the blended billing code could help spur price competition by ensuring a biosimilar wouldn't be unfairly thought of as inferior to the higher-priced reference biologic.[26] Recent FDA guidance, however, set out requirements for how a biosimilar could be designated as an "interchangeable biologic" and therefore be substituted for the (likely) higher-priced reference biologic when being administered.[27] But it is important to note that this change does not directly change reimbursement policies, so its significance remains limited at this time.

In the past, CMS advanced policies that put in place some of the price checks a more traditional formulary management system can foster. For example, from 1995 to 2010, CMS reimbursed for the least costly alternative drug that was clinically comparable in order to encourage the selection of less-expensive, equally valuable treatments.[28] This policy was ultimately struck down in federal court, which ruled such a system needed Congressional authority.

PART B: MAJOR POLICY PROPOSALS

In examining drug coverage and spending under Part B, major themes emerge: a lack of competition, a lack of transparency, and perverse incentives that are causing significant financial burdens for Medicare and individuals. The following provides a brief overview of some of the most often-discussed policy proposals related to Medicare Part B to lower the costs of prescription drugs, though the potential effectiveness of some of these examples is in dispute:

Collapsing Part B Drug Coverage into Part D Plans

While the specifics of Part D are not the focus of this brief, some have proposed to move coverage of all Part B drugs to Part D Prescription Drug Plans to try to achieve savings. This significant change would require Part B drugs to be reimbursed and covered differently, for example, eliminating the ASP system of reimbursement and changing rules for coverage on these physician-administered drugs. There are concerns this change could also lead to higher prices and spending.

Part B-Specific Reforms

There are also several policy proposals to replace or modify the current system, ranging from dramatic to modest in scope, including:

- Implementing MedPAC's[29] recommended Part B Drug Value Program to allow providers to purchase drugs from private plans which will adopt formularies in order to negotiate prices;
- Increasing transparency and reporting requirements within Medicare and granting HHS the ability to penalize pharmaceutical companies that aren't in compliance with those requirements;
- Encouraging pricing competition through changes to benefit design and billing codes, such as adopting a least costly alternative standard or a single consolidated billing code for a reference biologic and biosimilars (often extremely expensive drugs with complex manufacturing processes).
- Increasing program integrity and preventing waste;
- Reforming WAC and ASP to ensure manufacturers aren't overcharging for certain drugs; and
- Adopting mechanisms to protect against significant price increases, such as an inflation-based rebate penalty on the manufacturer.

CONCLUSION

Aggressive action is needed on both an administrative and legislative level to correct the trend of higher spending and ensure Medicare and beneficiaries don't continue to bear the impact of unreasonable and growing drug prices. Reflecting the significant role biologics are playing in driving drug spending, Part B is transforming not only the financing of the program, but U.S. drug spending overall. Targeted policies to eliminate perverse incentives under the ASP system, even as broader reforms to Part B are discussed, would go far in improving Medicare for taxpayers and patients.

ENDNOTES

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