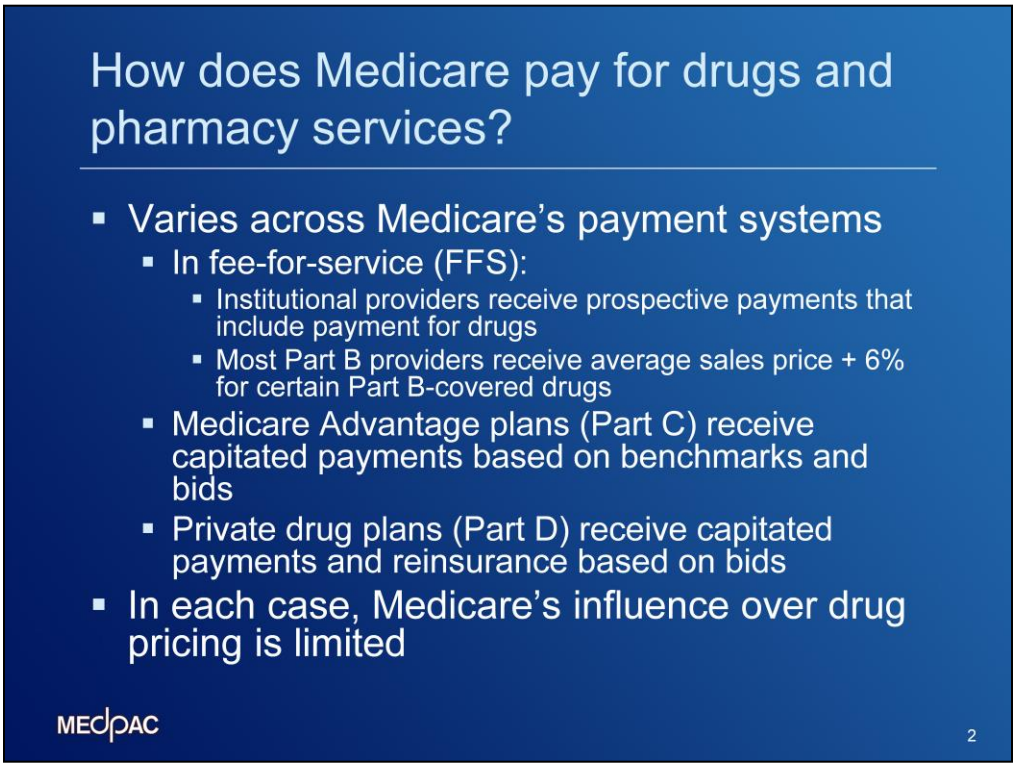
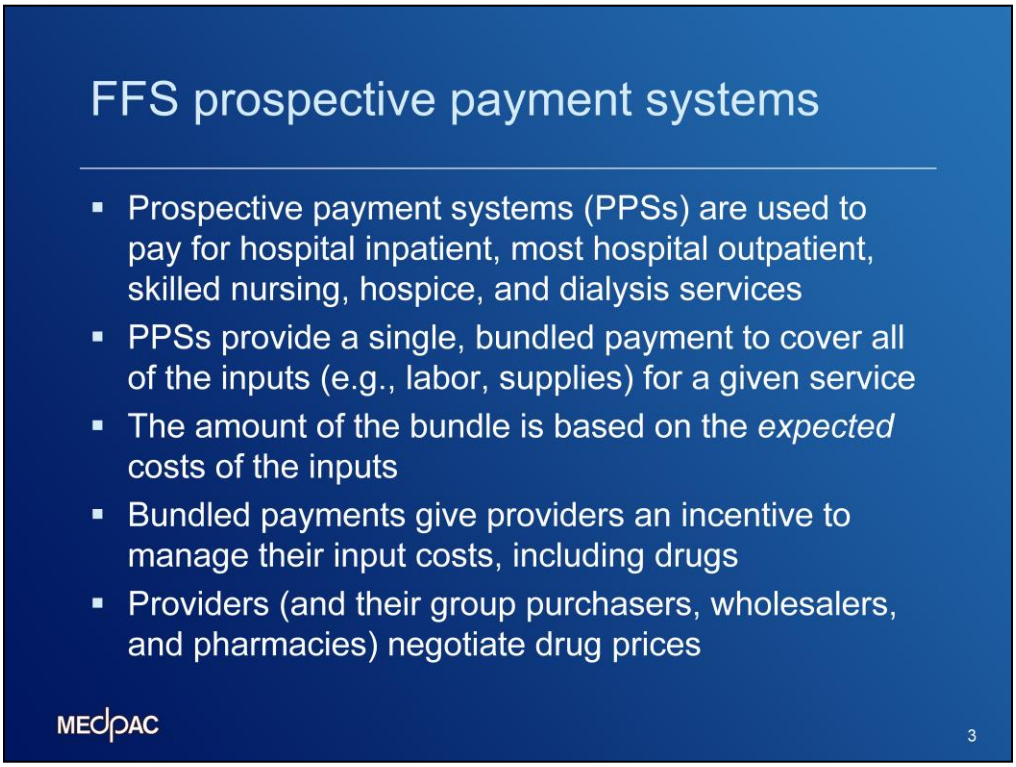
Prescription drugs are a critical component of health care. Because of the role of drugs in treating conditions, it is important that Medicare ensures that its beneficiaries have access to appropriate medication therapies. By providing benefits that include prescription drug coverage, Medicare has expanded patient access to needed medications. However, it is becoming increasingly difficult to make sure that access to medications remains affordable for beneficiaries and to keep Medicare financially sustainable for taxpayers.

This brief provides background information on how Medicare pays for drugs and examines the magnitude of Medicare drug spending across Medicare's various payment systems. This is the first of two informational briefs that the Commission has created to provide background for thinking about Medicare drug policies; the second brief provides a broader view of the American drug market, including the drug development and approval processes and drug-related industries such as pharmacies and pharmacy benefit managers.



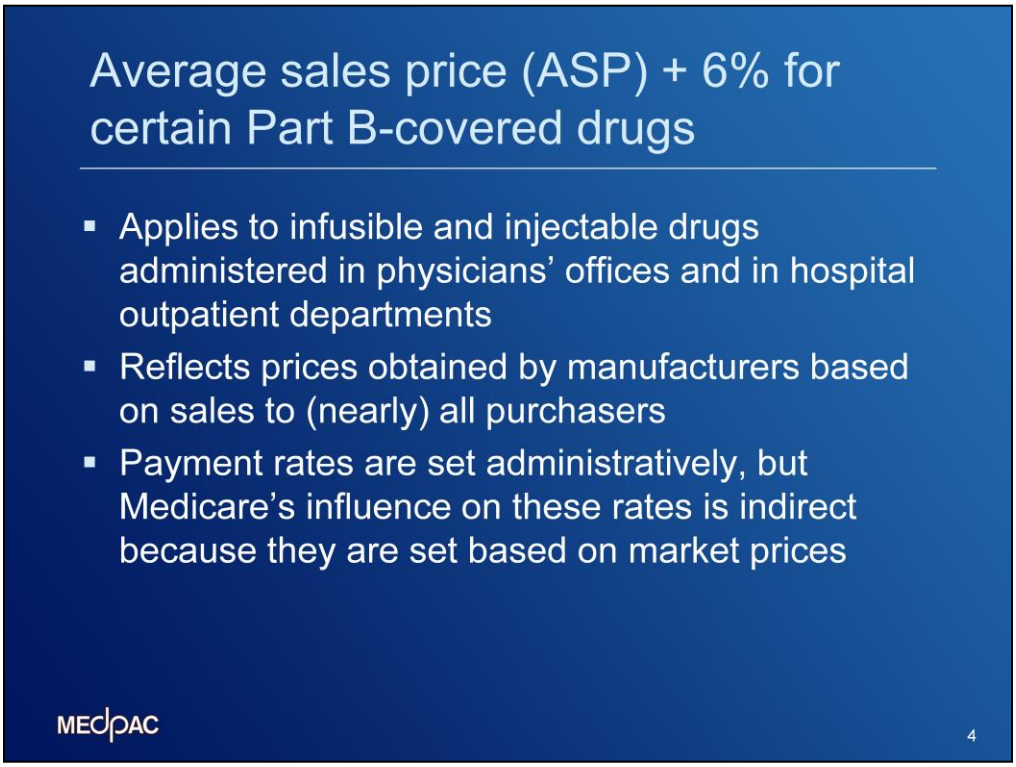
Medicare pays for drugs and pharmacy services in different ways across its various payment systems. Medicare pays most types of institutional providers prospective payments for their services, and part of those payments covers the cost of drugs. Service providers are paid separately for certain Part B–covered drugs based on their average sales price plus a six percent add-on. Medicare Advantage plans receive capitated payments based on fee-for-service (FFS) benchmarks and bids for their broad bundle of Part A and Part B services (including Part B–covered drugs). And under Part D, Medicare uses a combination of capitated payments based on plan bids and reinsurance subsidies for catastrophic costs to pay private drug plans.

The next several slides will cover these payment systems in more detail, but generally in each case Medicare's influence over drug pricing is limited. Typically it is the provider of the health care service or the plan that negotiates prices for drugs, not Medicare.



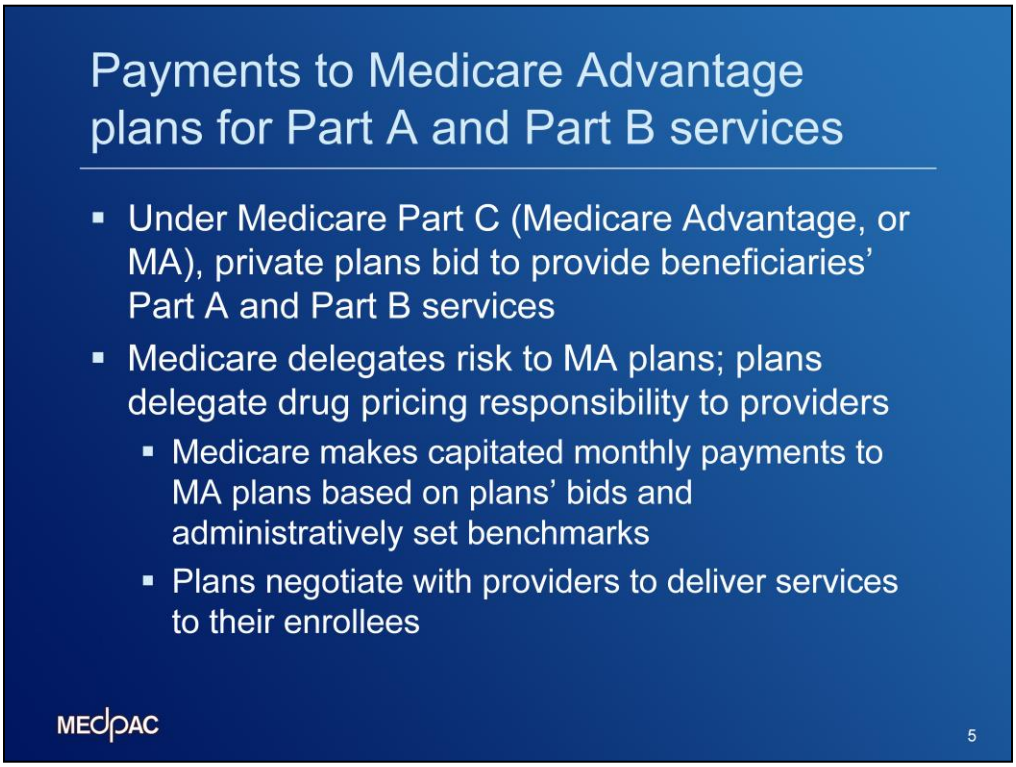
Prospective payment bundles are used to pay for Part A and some Part B services. They provide a single, bundled payment to cover all of the inputs (e.g., labor, supplies) for a given service. Examples include inpatient and outpatient prospective payment systems and the outpatient dialysis payment system. For skilled nursing facility and hospice services, Medicare bases payments on per diem rates. The payment rate for the bundle is based on the *expected* costs of inputs, rather than providers' actual input costs. These prospective payment bundles are intended to give providers incentives to manage their costs of care. If a provider can keep its costs below the level assumed by the bundle, it gets to keep the difference between expected and actual costs as profit. However, if a provider's costs are larger than what is assumed by the bundled payment, the payment will not be enough to cover its costs.

The cost of drugs in these payment bundles reflects prices that providers, their group purchasers, wholesalers, and pharmacies negotiated with manufacturers—meaning that Medicare does not have a direct influence over the prices paid for drugs included in the payment bundles.



Medicare pays separately for most (but not all) Part B–covered infusible and injectable drugs administered in physicians' offices and hospital outpatient departments.

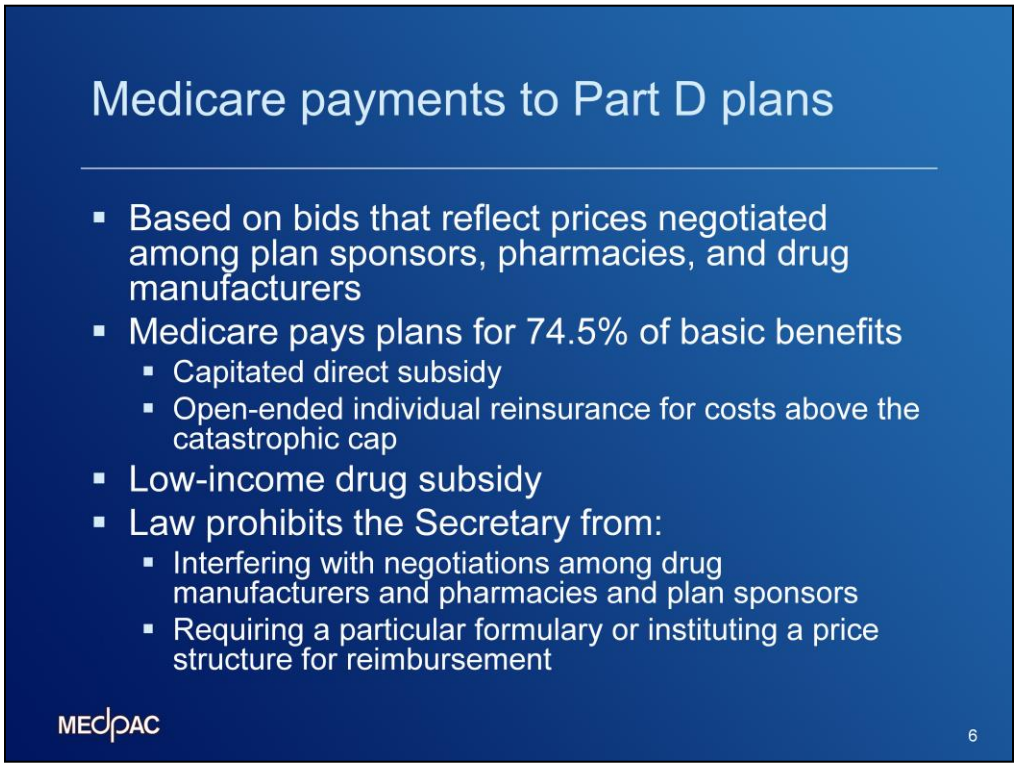
By law, the payments for these drugs are set at the average sales price (ASP) plus 6 percent. The ASP reflects the average price realized by the manufacturers based on sales to nearly all purchasers. Thus, although the payment rates for Part B drugs are set administratively by CMS, the use of market-based ASP data to set these rates means that Medicare's influence on the prices it pays is indirect.



Medicare Part C, also known as the Medicare Advantage (MA) program, allows Medicare beneficiaries to receive their Medicare Part A and Part B benefits from private plans rather than from the traditional fee-for-service (FFS) program. MA plans submit bids to provide these benefits to their enrollees, and then receive capitated monthly payments from Medicare based on their bids and administratively set benchmarks. Plans are at risk for their enrollees' spending, meaning that if a plan's costs to deliver benefits are higher than the payments it receives from Medicare, it must bear that loss. Conversely, if a plan's benefit costs are lower than Medicare's payments, the plan gets to keep the profit. Plans therefore have a strong incentive to control their enrollees' medical costs.

MA plans create provider networks and negotiate payment rates with providers that are in their networks. Like FFS Medicare, MA plans often use prospective payment systems to pay service providers. Therefore, MA generally also passes on to providers the responsibility (and risk) of negotiating prices for drugs that are inputs to Part A– and Part B–covered services. In this instance, Medicare is two levels removed from negotiations over drug prices—it delegates risk to plans, which in turn delegate risk to providers.

Many MA plans also offer Part D prescription drug benefits in addition to providing Part A and Part B benefits. MA plans that offer prescription drug coverage are known as MA–PD plans. Medicare's payment methodology for Part D, which will be addressed next, applies to both MA–PD plans and stand-alone prescription drugs plans (PDPs).

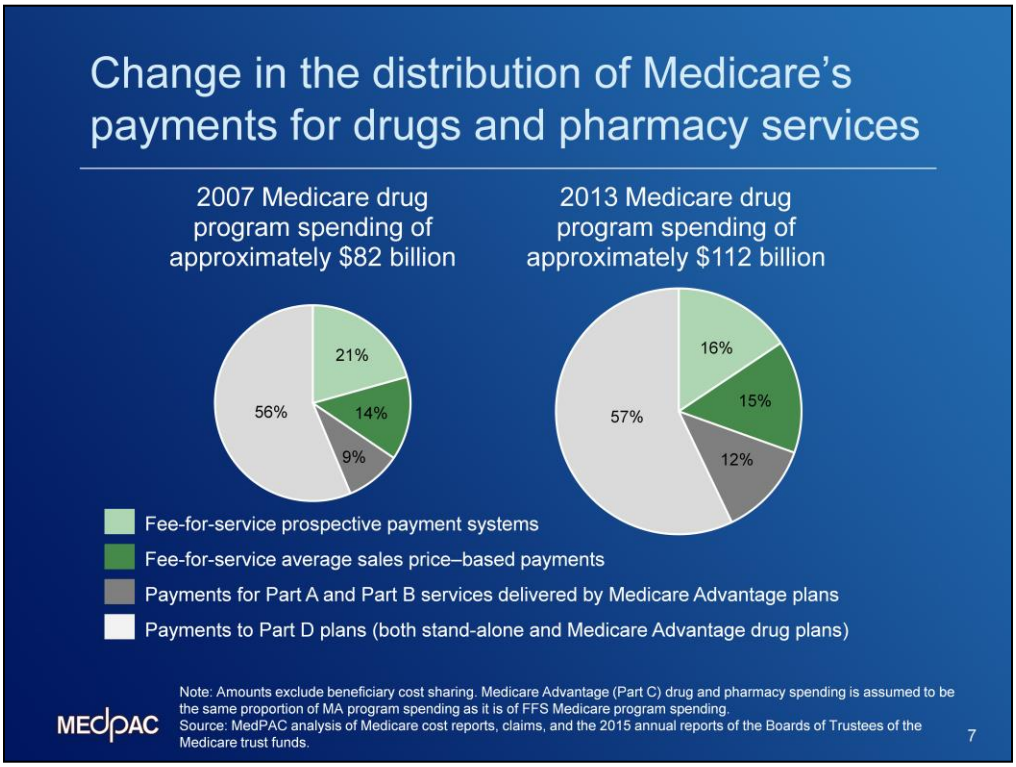


Part D accounts for over half of all payments for drugs by the Medicare program. As with other payment systems, Medicare has little direct effect over prices for outpatient drugs covered under the Part D program because it pays plans based on bids that plans submit, which reflect prices negotiated among plans, pharmacies, and drug manufacturers.

The bids are essentially premiums that plans need to collect in order to provide the benefit. Medicare subsidizes the premium through two forms of payments—the capitated direct subsidy payment for each enrollee and an open-ended individual reinsurance payment for costs above the catastrophic cap. While plans are at risk for the benefit spending covered by the direct subsidy, Medicare pays for individual reinsurance that covers 80 percent of spending above the catastrophic cap, also known as the out-of-pocket threshold. These two payments, for the direct subsidy and expected reinsurance, make up 74.5 percent of total premiums. The remaining 25.5 percent is paid by Part D enrollees.

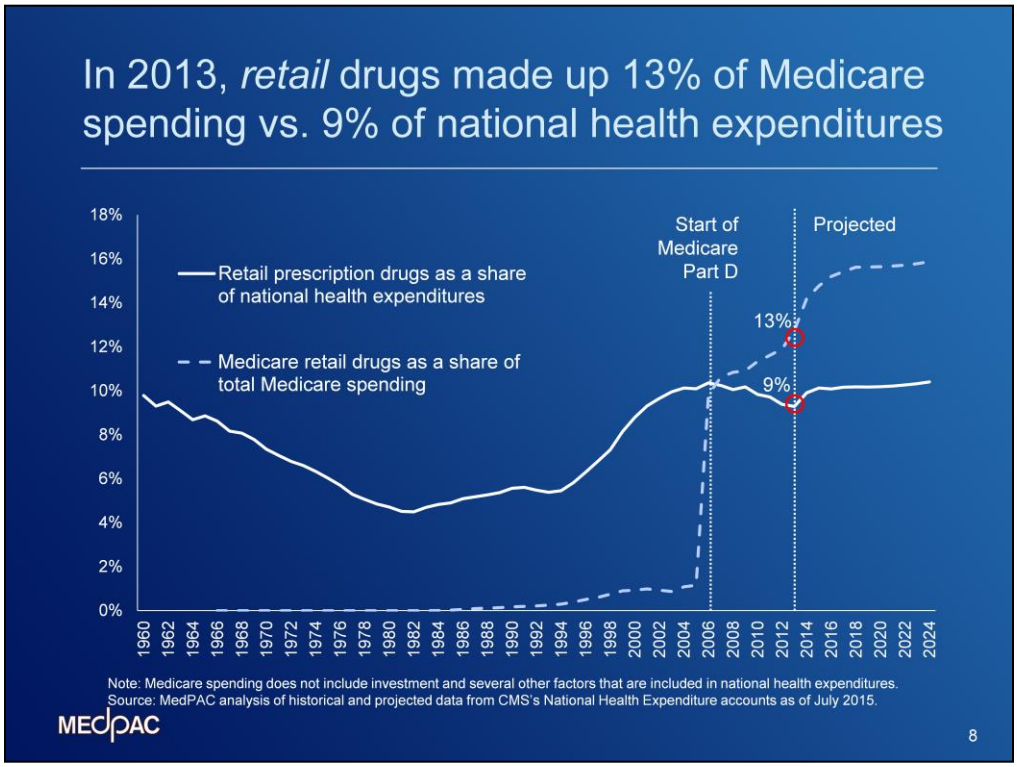
In addition, Medicare pays plans for most of the cost sharing and premiums for their low-income beneficiaries, known as the low-income drug subsidy, or LIS.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which created the Part D program, includes a provision that prohibits the government from interfering with the negotiations among drug manufacturers, pharmacies, and plan sponsors. It also prohibits the government from requiring a particular formulary or instituting a price structure for reimbursement.

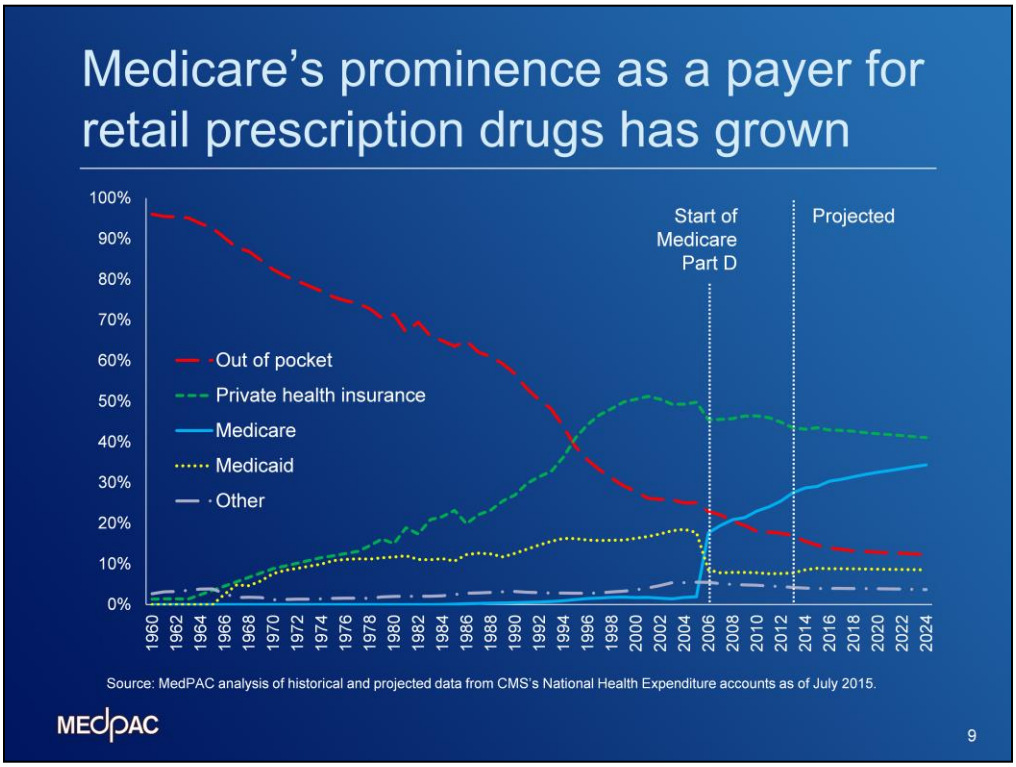


Medicare spent approximately $82 billion on drugs in 2007. Among the four major mechanisms through which Medicare pays for drugs, program spending for Part D made up 56 percent, followed by 21 percent for drugs paid within prospective payment systems, 14 percent under ASP-based payments, and 9 percent for Part A and Part B services delivered within Medicare Advantage plans.

The distribution for 2013 did not change significantly. The Commission estimates that total Medicare drug spending was about $112 billion, with Part D program spending making up 57 percent of the total. The proportion associated with prospective payments fell to 16 percent, but that mostly reflects the growth in enrollment in Medicare Advantage plans.



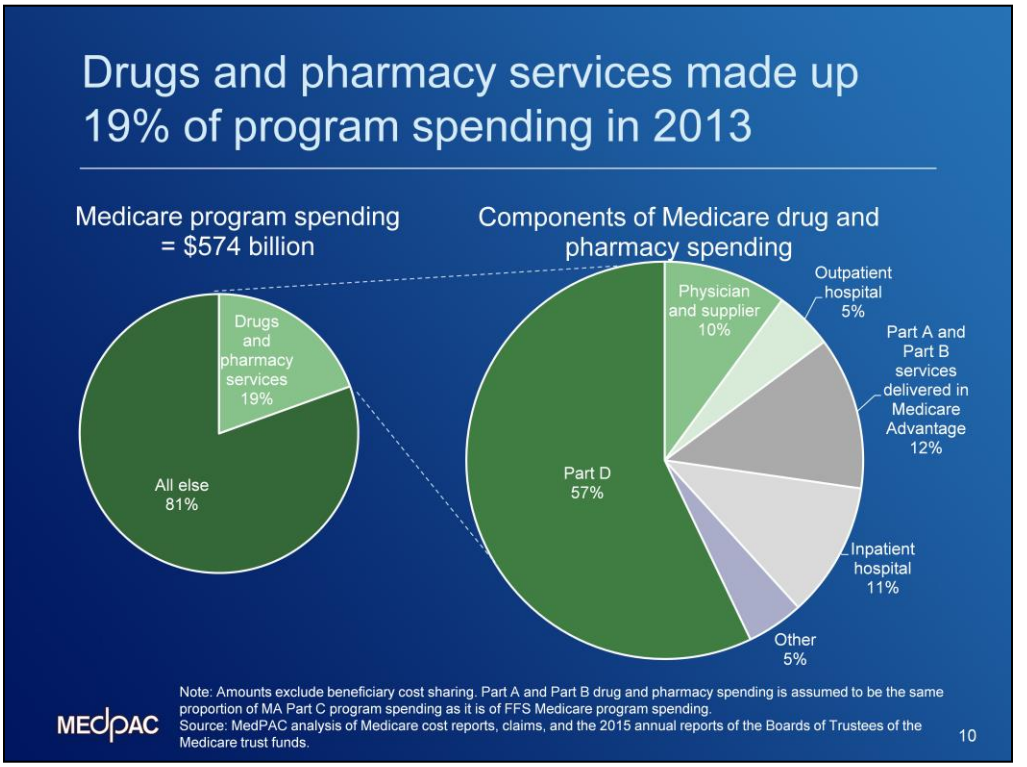
The National Health Expenditure accounts, developed and maintained by CMS's Office of the Actuary, include ***retail*** prescription drug spending, such as when Part D enrollees fill a prescription at a retail pharmacy or grocery store, or when a physician's office buys drugs to administer to patients. In 2013, across all payers, retail drug spending made up 9 percent of all national health expenditures. However, retail drugs made up a higher share of all Medicare spending—13 percent. Medicare's retail spending in 2013 reflects Part D program spending of $64 billion and another $10 billion in prescription drugs billed separately under Part B.



Since 2006 when the Part D program began, Medicare's prominence as a payer for prescription drugs has grown. Before 2006, retail drug purchases paid by Medicare only made up 2 percent of total drug spending. Medicare's share jumped immediately to 18 percent in 2006 because of Part D, and its share grew to 28 percent by 2013. The Office of the Actuary projects that Medicare's share of total retail drug spending will reach 34 percent by 2024.

Medicaid's share fell dramatically in 2006 as Medicare took over most of the responsibility for the drug spending of beneficiaries who are dually eligible for Medicare and Medicaid.

There has also been a long-term downward trend in the share of retail drug spending paid out of pocket by patients. This trend has been driven by expansion in the availability of insurance coverage for drugs, including through employer plans, Medicaid, and the establishment of Part D in Medicare. Private health insurance, mostly provided through employers, has historically been a very important payer for drugs. It is still very important, but its share has been declining.



The Commission developed estimates of Medicare drug spending that include not only retail drug spending, which is the typical metric used to describe the magnitude of drug spending, but also spending for drugs and pharmacy services used as inputs at health care facilities, which is not typically included in drug spending measures. These estimates are based on Medicare cost reports, Medicare claims, and estimates of program spending from the Trustees reports. Ultimately the estimates are all in terms of what the Medicare program paid.

Medicare program spending totaled $574 billion in 2013, and the Commission estimates that drugs and pharmacy services made up 19 percent of that total. The Commission also estimates that drugs and pharmacy services made up 19 percent of Medicare program spending in 2007. In comparison, most estimates typically only account for retail prescription drugs, and attributed about 10 percent of total medical spending to drugs and pharmacy services.