



*Advising the Congress on Medicare issues*

# Part B drug payment policy issues

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# Outline of presentation

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- Background on Part B covered drugs and the average sales price payment (ASP) system
- Policy alternatives to Medicare's payment of 106% of ASP
- Background on the 340B drug pricing program
- Estimates of 340B discounts and Medicare payments

# Background on Part B drugs and Medicare payment

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- Medicare spent more than \$19 billion in 2013 on Part B covered drugs, including:
  - Drugs administered in physician offices or hospital outpatient departments considered “not usually self-administered” (e.g., chemotherapy infusions, eye injections)
  - Certain drugs furnished by suppliers (e.g., inhalation drugs; oral-anticancer, antiemetic, and immunosuppressive drugs)
- Medicare pays providers for most Part B drugs at a prospective rate equal to 106% of the average sales price (ASP)
- Concern expressed about the 6% add-on to ASP potentially incentivizing use of higher-priced drugs

# Background on ASP

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- ASP is not the actual price an individual provider pays for the drug
- ASP reflects the average price realized by the drug manufacturer for sales to all purchasers (with exceptions) net of rebates, discounts, and price concessions
- Manufacturers report ASP data to CMS quarterly
- The ASP+6% payment rate for a drug each quarter is based on ASP data from two quarters prior

# Does the 6% add-on to ASP incentivize the use of higher priced drugs?

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- Few studies exist examining the effect of the 6% add-on on provider prescribing patterns
- Conceptually, a 6% margin on Part B drugs could incentivize the use of higher-priced drugs if there were differently priced substitutes available
- Providers' actual margins on Part B drugs likely vary across drugs and providers due to:
  - Price variation across purchasers
  - Price changes and two-quarter lag in ASP+6 rate
  - Prompt pay discounts not passed on to final purchasers
  - Other factors (e.g., wholesaler mark-up or sales tax)

# Modeling policy alternatives to 106% ASP that include a flat add-on

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- Modeled two policy options that were budget neutral to ASP+6%
  - Option 1: 100% ASP + \$24 per drug administered per day
  - Option 2: 102.5% ASP + \$14 per drug administered per day
- Modeled budget neutrality under the assumption of no change in utilization
- Modeled pre-sequester payment rates

# Comparison of payment rates under current policy and illustrative options

ASP per admin.	Payment rate (in dollars)			Payment rate (expressed as %ASP)	
	Current rate: 106% ASP	Option 1: 100% ASP + \$24	Option 2: 102.5% ASP + \$14	Option 1: 100% ASP + \$24	Option 2: 102.5% ASP + \$14
\$10	\$10.60	\$34	\$24.25	340.0%	242.5%
\$100	\$106	\$124	\$117	124.0%	116.5%
\$400	\$424	\$424	\$424	106.0%	106.0%
\$1000	\$1,060	\$1,024	\$1,039	102.4%	103.9%
\$2500	\$2,650	\$2,524	\$2,577	101.0%	103.1%
\$5000	\$5,300	\$5,024	\$5,139	100.5%	102.8%

Note: Payment amounts are before the application of the sequester. ASP per administration (admin) is defined as the ASP unit price times the number of units of the drug furnished to the patient on a particular day. Under the two policy options, the flat fee add-on is paid per drug per administration day (regardless of the number of units administered). For drugs furnished by suppliers, the flat add-on is assumed to be paid per prescription.

# Implication of policy options for low-priced drugs

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- Payment rates for low-priced drugs would increase
- May create incentives for:
  - Substitution of low-priced drugs for high-priced drugs where therapeutic alternatives exist
  - More use of low-priced drugs in general since relatively large margin



# Implications of policy options for high-priced drugs

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Would providers be able to obtain very expensive drugs within the Medicare payment rate?

- Option 1 (100% ASP + \$24): providers may have difficulty purchasing some very expensive drugs within the Medicare rate
- Option 2 (102.5% ASP + \$14): more likely providers would be able to purchase very expensive drugs within the Medicare rate
- Would depend on how drug manufacturers respond. For example, following implementation of ASP+6% in 2005, manufacturers reduced price variation across purchasers.
- Estimates are pre-sequester

# A flat add-on would redistribute revenues across providers

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- A flat add-on would increase payments to suppliers and physicians overall, but decrease payments to hospitals and some physician specialties
- For example, under option 2, Part B drug revenues are estimated to:
  - Increase for physicians overall (0.8%)
  - Decrease for oncologists (-0.9%), ophthalmologists (-2.2%), and rheumatologists (-1.4%)
  - Increase for primary care (6.5%) and other specialties (7.5%)
  - Decrease for outpatient hospitals (-2.2%)
  - Increase for suppliers (4.5%)

# Background on 340B Drug Pricing Program

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- Allows certain providers (“covered entities”) to obtain discounted prices on outpatient drugs (prescription drugs and biologicals other than vaccines)
- Covered entities include DSH hospitals, CAHs, other hospitals, certain clinics
- Discounts under 340B comparable to Medicaid drug rebates
- Program has grown rapidly since 2005 (spending on drugs, number of covered entities)

# Medicare pays for 340B drugs provided by covered entities to beneficiaries

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- Under outpatient PPS, Medicare pays same rates for Part B drugs to 340B hospitals and non-340B hospitals, even though 340B hospitals can purchase drugs at steep discounts
- Medicare spending for Part B drugs at 340B hospitals grew from \$0.5 billion in 2004 to \$3.4 billion in 2013

# HRSA sets 340B ceiling prices for outpatient drugs

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- Ceiling price = maximum price manufacturer can charge for 340B drug
- Based on statutory formula used to calculate Medicaid drug rebates
- HRSA maintains file of ceiling prices for covered entities but prohibited from publicly disclosing them

# Estimating discount on outpatient drugs for 340B hospitals

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- To precisely calculate discount, need to know average manufacturer price (AMP) and best price, which are confidential
- We approximated average discount by using ASP (public data) as a proxy for AMP and applying minimum statutory rebate
  - 23.1% for brand drugs
  - 13% for generic drugs
- Average discount = 22.5%\* of ASP

\*22.5% is weighted average of rebate for brand drugs and generic drugs.

# Estimated discount of 22.5% is lower bound of actual discount

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- AMP usually greater than ASP
- We don't have access to best price data
- Without AMP data, we can't calculate the inflation rebate, which is added if AMP has grown faster than inflation since drug's market date
- HRSA contractor (Apexus) negotiates steeper discounts on certain drugs

# Difference between Medicare payments and acquisition cost for 340B hospitals, 2013

Categories, 340B hospitals	OPD drug rev	Acquisition cost	OPD drug rev - Cost		
			Dollars	% overall rev	% OPD rev
All hospitals	\$3.2	\$2.4	\$0.8	1.1%	4.5%
Urban	3.0	2.2	0.8	1.1	4.7
Rural	0.3	0.2	0.1	1.0	3.0
Major teaching	1.4	1.0	0.4	1.3	5.8
Other teaching	1.1	0.8	0.3	1.0	4.3
Non teaching	0.7	0.6	0.2	0.9	3.3
Non-profit	2.5	1.8	0.6	1.1	4.4
Government	0.8	0.6	0.2	1.2	4.8

Note: Dollar amounts are in billions. We excluded 340B hospitals that are CAHs and those for which we did not have OPD revenue or overall Medicare revenue.

Source: MedPAC analysis of Medicare claims and HRSA file on hospital 340B participation, 2013



# Discussion

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- Clarifications
- Additional information
- Reactions to policy options on 6% add-on
- Policy options for 340B?