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Pricing debate puts Medicare drug reimbursement in play again

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The US Medicare programme has yet to get a grip on spending for physician-administered speciality drugs. A congressional advisory panel is attempting to do so in a recommendation to trim reimbursement rates and encourage drug competition ahead of a transition to competitive bidding.

Pharmaceutical manufacturers and oncology clinics oppose the proposal, which would need congressional approval and a presidential signature to be enacted. But with drug prices remaining a high-profile political topic thanks, among other things, to President Donald Trump's threats the panel's recommendation could make it into cost-control legislation.

The proposal restarts the debate on controlling spending in part B of the Medicare programme, which governs reimbursement to physician practices, outpatient clinics, nursing homes and other non-hospital institutions that treat Americans 65 and over. Medicare reimburses physicians at the average sales price (ASP) plus a 6% markup, although the rationale for the markup is unclear even among policymakers – however, the current framework is blamed for 9% annual spending growth.

These new recommendations from the congressional advisory committee called the Medicare Payment Advisory Commission (Medpac) are estimated to save the programme $250-750m a year. Medicare spent about $25bn on drugs in part B of the programme in 2015.

Last year, the Centers for Medicare and Medicaid Services (CMS) proposed and then shelved a plan to cut the markup to 2.5% and add a flat fee of $16.80, a plan that the agency said would reduce the margin on high-cost drugs and increase the incentive to use lower-cost alternatives (*Medicare opens limited front in US pricing war, March 10, 2016*).

A whack to the WAC

Medpac's recommendation has similarities. It cuts the price for new, high-expenditure drugs where the ASP is calculated to be the same as the wholesale acquisition cost (WAC) – essentially the list price of the drug – to WAC plus 3%.

For drugs using the ASP benchmark, the commission does not recommend eliminating the 6% markup but does propose requiring rebates for drugs where price increases exceed an inflation benchmark like the consumer price index. To enable better monitoring of ASP increases, Medpac recommends more robust enforcement of price reporting.

Furthermore, Medpac proposes a single billing code for biologics and their biologic competitors to enable price competition for off-patent agents.

These are all short-term measures recommended for implementation in 2018. The commission's work also takes a longer view, proposing a transition to a "drug value programme" that would resuscitate competitive bidding in this sector.

Value through competitive bidding

By 2022, Medpac recommends that Medicare contract with pharmacy benefit managers (PBMs) to negotiate prices with pharmaceutical manufacturers and supply doctors' offices – prices could be no higher than the ASP for a given drug. This would resume a competitive bidding effort that was deferred in 2008 after it failed to reduce costs and struggled to enrol physicians (*Vantage point – Price restraint talks hit reality bump, April 12, 2017*).

Medpac recommends that Medicare empower the PBMs to set formularies and manage access through prior authorisation and step therapy – CMS's earlier competitive bidding effort had an open formulary, which limited the PBMs' power to negotiate lower prices.

Medicare will then reimburse physicians at the price established by the PBM that supplies them, along with an

administrative fee paid to the PBM. Enrolee cost-sharing would be based on the price paid by the vendor, reducing their financial exposure.

The plan has gained opposition from the Pharmaceutical Research and Manufacturers of America (PhRMA) and the Community Oncology Alliance, which say the cut to the add-on will make it cost-prohibitive to continue to provide drug administration to patients and drive treatment into the more expensive hospital setting. PhRMA also said the drug value programme would limit access for beneficiaries unnecessarily because the ASP mechanism has yielded price moderation.

Whatever the case, the Medpac recommendation does not propose a revival of a separate plan under the aborted CMS part B plan last year to transition to “value-based pricing” – such as reimbursement based on real-world outcomes, indication specific payment, or compensation only for patients who respond to medication.

Taking the less complex road of competitive bidding rather than value-based pricing may be attractive to lawmakers as well as the White House. In the big picture, Mr Trump is looking for $900bn in health care savings over 10 years to help pay for tax reform – a proposal that saves up to $750m a year will help get him there.

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