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Why competitive bidding will be a hard task in Medicare

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The US government is trying to change the way Medicare reimburses doctors for office-administered drugs – but whether it will succeed is another story.

The way in which the US Medicare programme pays for drugs administered in physician offices is a relic of the past. Quirks of the law allow practices to capture a significant portion of this revenue stream, and politicians are once again trying to bring these costs under control.

Whether the new competitive acquisition initiative growing out of President Donald Trump's drug pricing blueprint will be more successful than past efforts is anybody's guess – an experiment a decade ago failed because of botched execution and lack of interest from physicians. Facing a revenue loss, doctors will put their formidable lobbying muscle to work to seek some compensation, making cost savings harder to make.

Buy and bill

Medicare, the health programme for the elderly, reimburses physicians for office-administered drugs based on their average sales price plus a 6% markup to account for storage, handling and administrative costs. This fee falls under "part B" of the programme, which covers all care outside institutional settings; part B accounted for $26bn of Medicare spending in 2016. The US government has been trying to eliminate such "buy-and-bill" payment practices, with part B drugs being one artefact.

Since there is no incentive for physicians to seek the cheapest drugs, policymakers have been concerned that they will favour more expensive ones because the percentage markup gives them a larger profit. Competitive acquisition has been proposed as one solution to this, and a leading alternative suggests cutting the add-on for the highest-price drugs.

Top 10 Medicare part B drugs ranked by total spending, 2016			
Brand	**Company**	**Total spending ($m)**	**Avg spending per beneficiary**
Eylea	Regeneron	$2,208	$10,497
Rituxan	Roche	$1,666	$23,815
Neulasta	Amgen	$1,376	$14,336
Remicade	Johnson & Johnson	$1,339	$22,925
Avastin	Roche	$1,112	$5,360
Prolia	Amgen	$1,087	$2,592
Lucentis	Roche	$1,044	$9,814
Herceptin	Roche	$704	$34,000
Prevnar 13	Pfizer	$669	$170
Orencia	Bristol-Myers Squibb	$587	$25,636
Source: Centers for Medicare and Medicaid Services.			

Implementing a competitive acquisition programme (CAP) could serve as a nice easy win for an administration that has tried to make a name for itself by easing healthcare costs but has little to show for it. The government already has the authority to impose such a rule, thanks to a 2003 law.

Once bitten

The last time something similar was tried was in 2006, with the CAP for a set of 180 drugs that mostly treated cancer, rheumatic diseases, ophthalmology and psychiatric conditions.

Instead of having physician practices acquire office-administered drugs, the Centers for Medicare and Medicaid Services (CMS) wanted to have drug distributors bid to become vendors who would in turn supply drugs to those practices that enrolled, eliminating the need for practices to bill Medicare. Participation was voluntary for physicians.

Top 10 Medicare part B drugs ranked by spending per beneficiary, 2016			
Brand	**Company**	**Avg spending per beneficiary**	**Total spending ($m)**
Rixubis	Shire	$559,638	$12.3
Novoseven RT	Novo Nordisk	$530,494	$78.5
Lumizyme	Sanofi	$504,575	$61.6
Alprolix	Sanofi	$464,531	$41.8
Soliris	Alexion	$382,631	$267.1
Feiba NF	Shire	$319,521	$51.1
Elaprase	Shire	$309,303	$1.2
Corifact	CSL	$291,679	$2.9
Cerezyme	Sanofi	$267,909	$40.5
Vpriv	Shire	$265,755	$24.5
Source: Centers for Medicare and Medicaid Services.			

The CAP was plagued by low enrolment – only one vendor signed a contract and only about 1,000 physicians a year joined – and it never achieved cost savings because of the way reimbursement to the vendor was calculated. Another issue was that the vendor, Bioscrip, only had authority to set formularies in classes that had generic options, not those in which there were multiple branded options with equivalent benefits.

CMS suspended the CAP in 2008.

Try and try again

The agency clearly knows what went wrong with the first try – its own analysis is exhaustive. The question is whether it has the capability to implement a programme that will achieve the desired cost savings.

Making it compulsory for physician practices to join is one possibility to build the scale necessary to attract multiple vendors, Cowen analyst Rick Weissenstein suggests. A weakness in that approach would be that physicians could see a reduction in their income from administering drugs, he says, so a fee might have to be instituted to make up for those losses. This would by definition limit the cost savings.

An alternative proposal from the Medicare Payment Advisory Commission, a congressional panel, would be to share the programme's cost savings with participating physicians, although again this would necessarily reduce the benefit to the taxpayer. Whatever the approach, Mr Weissenstein writes, any "transfer of money from pharma to physicians might be considered a positive outcome for the administration."

Another possible alteration would be to reduce the number of drugs subject to the CAP, which would ease administration and reduce the number of doctors who might oppose it because they stand to lose revenue.

In any case, the earliest a new CAP could be implemented would be 2020, since the CMS would be required to draft a new set of regulations, Mr Weissenstein wrote. And it would likely spark controversy both in the pharma sector and among physicians. The latter represents one of the strongest lobby groups in Washington, with one estimate putting the number of interactions between physicians and lawmakers at 29,000 a year.

Related to competitive acquisition is a proposal in the administration price blueprint to shift some part B drugs to part D, subjecting them to the threat of formulary exclusions because they are administered by private insurance plans. As Bernstein analyst Ronny Gal points out, this could have the effect of speeding biosimilar adoption or accelerating branded price erosion, since nine of the top 10 drugs by Medicare spending totals will face significant competition by 2025.

The complex US system of drug channels, payers and reimbursement schemes makes it difficult for any player to gain control of prices and costs. Successfully subjecting physician-administered drugs to competitive acquisition might generate some cost savings in a small subset of the pharma sector, but it will likely have only a marginal impact on overall spending. And the number of players trying to protect their incomes makes even such a modest goal a tall order.

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