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Proposal to Cap Part B Pay on Some Drugs Draws Opposition

Kerry Dooley Young

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An influential panel proposed capping Medicare Part B pay for some drugs, arguing this would remove financial incentives to use more costly medicines when there are less expensive equivalents.

Medical groups have objected to both this recommendation from the Medicare Payment Advisory Commission (MedPAC) and the panel's underlying premise. MedPAC said financial as well as clinical factors can come into play in clinicians' choices of drugs for patients.

In an interview, Christina Downey, MD, chair of the Government Affairs Committee of the American College of Rheumatology, said physicians in her field cannot switch patients' medicines to try to make a profit.

"Patients only respond to the drugs that they respond to," Downey said. "It's frankly very insulting to say that physicians just force patients to go on medicines that are going to make them a bunch of money."

In a June report to Congress, MedPAC recommended reducing the add-on payment for many drugs given in hospitals and clinics, and which are thus covered by Part B, as part of a package of suggestions for addressing rising costs. Part B drug spending grew about 9% annually between 2009 and 2021, rising from $15.4 billion to $42.9 billion, MedPAC said.

Medicare's current Part B drug pricing model starts with the reported average sales price (ASP) and then adds about 4.3% or 6%, depending on current budget-sequester law, to the cost of medicines.

MedPAC members voted 17-0 in April in favor of a general recommendation to revise the Part B payment approach. In the June report, MedPAC fleshes out this idea. It mentions a model in which the add-on Part B payment would be the lesser of either 6% of the ASP, 3% plus $24, or $220.

The majority of Part B drug administrations are for very low-priced drugs, MedPAC said. But for some of the more costly ones, annual prices can be more than $400,000 per patient, and future launch prices may be even higher for certain types of products, such as gene therapies, MedPAC said.

"There is no evidence that the costs of a drug's administration are proportionate to the price of the drug," MedPAC said.

Concerns about how well Medicare covers the cost of drug administration should be addressed through other pathways, such as the American Medical

Association's Specialty Society Relative Value Scale Update Committee (RUC), MedPAC said. AMA's RUC advises the Centers for Medicare & Medicaid Services (CMS) on the physician fee schedule.

Congress is not obliged to act on or to even consider MedPAC's work. In general, lawmakers and CMS often pay heed to the panel's recommendations, sometimes incorporating them into new policy.

But this new MedPAC Part B recommendation has drawn strong opposition, similar to the response to a 2016 CMS plan to cut the Part B add-on payment. That plan, which CMS later abandoned, would have cut the markup on Part B drugs to 2.5% and added a flat fee to cover administration costs.

Why Not Focus on PBMs Instead?

The timing of the MedPAC recommendation is poor, given that CMS already is trying to implement the Inflation Reduction Act (IRA) and create a new system of direct Medicare drug price negotiations, as ordered by Congress, said Madelaine A. Feldman, MD, a rheumatologist based in New Orleans.

A better approach for lowering drug prices would be to focus more on the operations of pharmacy benefit managers (PBMs), said Feldman, who also is vice president for advocacy and government affairs for the Coalition of State Rheumatology Organization. A pending bipartisan Senate bill, for example, would prohibit PBM compensation based on the price of a drug as a condition of entering into a contract with a Medicare Part D plan.

Congress needs to take steps to unlink the profits of PBMs from higher drug prices, Feldman said.

"Until that happens, we can put all the lipstick we want on this big pig, but it's not going to really fix the problem," she said.

Reduced Pay for Drugs Acquired Through 340B Program?

In an interview about the new MedPAC proposal, Ted Okon, executive director of the Community Oncology Alliance, urged renewed attention to what he sees as unintended consequences of the 340B discount drug program.

Under this program, certain hospitals can acquire drugs at steeply reduced prices, but they are not obliged to share those discounts with patients. Hospitals that participate in the 340B program can gain funds when patients and their insurers, including Medicare, pay more for the medicines hospitals and other organizations acquired with the 340B discount. Hospitals say they use the money from the 340B program to expand resources in their communities.

But rapid growth of the program in recent years has led to questions, especially about the role of contract pharmacies that manage the program. Congress created the 340B program in 1992 as a workaround to then new rules on Medicaid drug coverage.

In 2021, participating hospitals and clinics and organizations purchased about $44 billion worth of medicines through the 340B drug program. This was an increase of 16% from the previous year, according to a report from the nonprofit Commonwealth Fund. The number of sites, including hospitals and pharmacies, enrolled in the 340B program rose from 8100 in 2000 to 50,000 by 2020, the report said.

MedPAC in 2016 urged CMS to reduce the amount Medicare pays for drugs acquired through the 340B program. CMS did so during the Trump administration, a policy later defended by the Biden administration.

But the US Supreme Court last year said Medicare erred in its approach to making this cut, as earlier reported by Medscape. Federal law required that the Department of Health and Human Services (HHS) conduct a survey to support such a step, and HHS did not do this, the court said. CMS thus was ordered to return Medicare to the ASP+6% payment model for drugs purchased through the 340B discount program.

In the June report, though, MedPAC stuck by its 2016 recommendation that Medicare reduce its payments for drugs purchased through the 340B discount program despite this setback.

"We continue to believe that this approach is appropriate, and the specific level of payment reduction could be considered further as newer data become available," MedPAC said.

Hospital, PhRMA Split

Hospitals would certainly contest any renewed bid by CMS to drop Medicare's pay for drugs purchased through the 340B program. The American Hospital Association (AHA) objected to the MedPAC proposal regarding the add-on payment in Part B drug pricing.

MedPAC commissioners discussed this idea at a January meeting, prompting a February letter from the AHA to the panel. Like Feldman, AHA also said it would be "premature" to launch into a revision of Part B drug pricing while the impact of the IRA on drug prices was still unclear.

AHA also noted that a reduction in Part B drug reimbursement would "shift the responsibility for the rapid increase in drug prices away from drug manufacturers, and instead places the burden on hospitals and patients."

But the AHA gave a much warmer reception to another proposal MedPAC considered this year and that it included in its June report, which is a plan to address the high cost of certain drugs of as yet unconfirmed clinical benefit.

In April, the AHA said it supports a move toward a "value-based approach" in certain cases in which first-in-class medicines are sold under US Food and Drug Administration's accelerated approvals. Medicare could then cap payment for such drugs that have excessively high launch prices and uncertain clinical benefit, AHA said.

In the June report, MedPAC recommended that Medicare be able to place such a limit on Part B payments in certain cases, including ones in which companies do not meet FDA deadlines for postmarketing confirmatory trials.

The Pharmaceutical Research and Manufacturers of America (PhRMA) objected to this proposed change. The trade group for drugmakers said the FDA often revises and extends enrollment milestones for pending confirmatory trials when companies hit snags, such as challenges in enrolling patients, PhRMA said.

Reducing Part B payment for drugs for which confirmatory trials have been delayed would have a "disproportionate impact" on smaller and rural communities, where independent practices struggle to keep their doors open as it is, PhRMA spokeswoman Nicole Longo wrote in a blog post.

"If physicians can't afford to administer a medicine, then they won't and that means their patients won't have access to them either," Longo wrote.

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