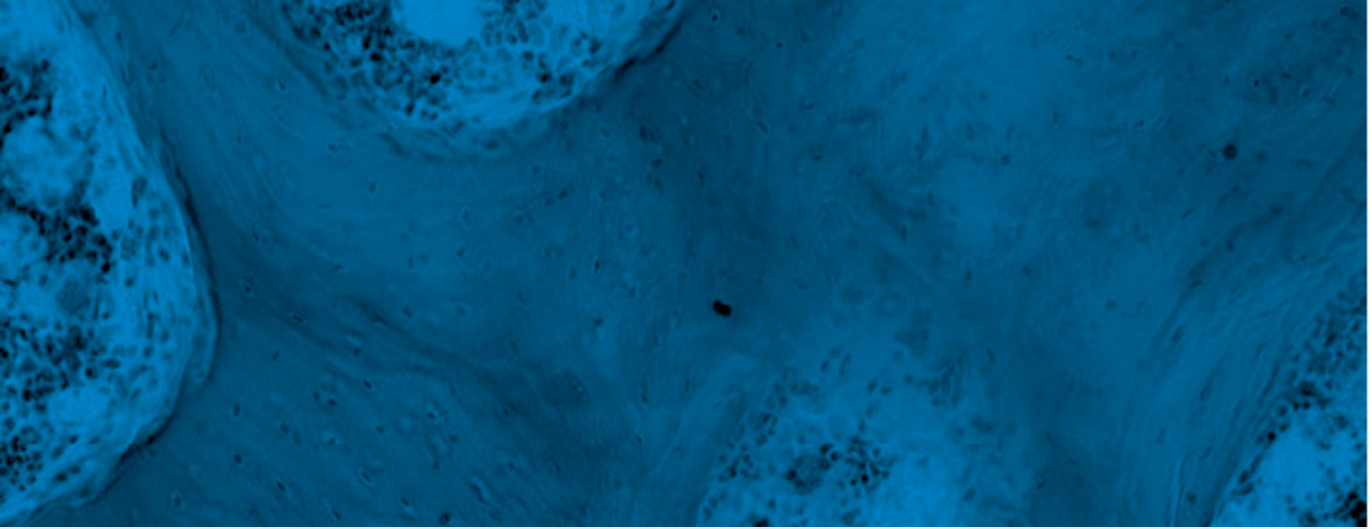
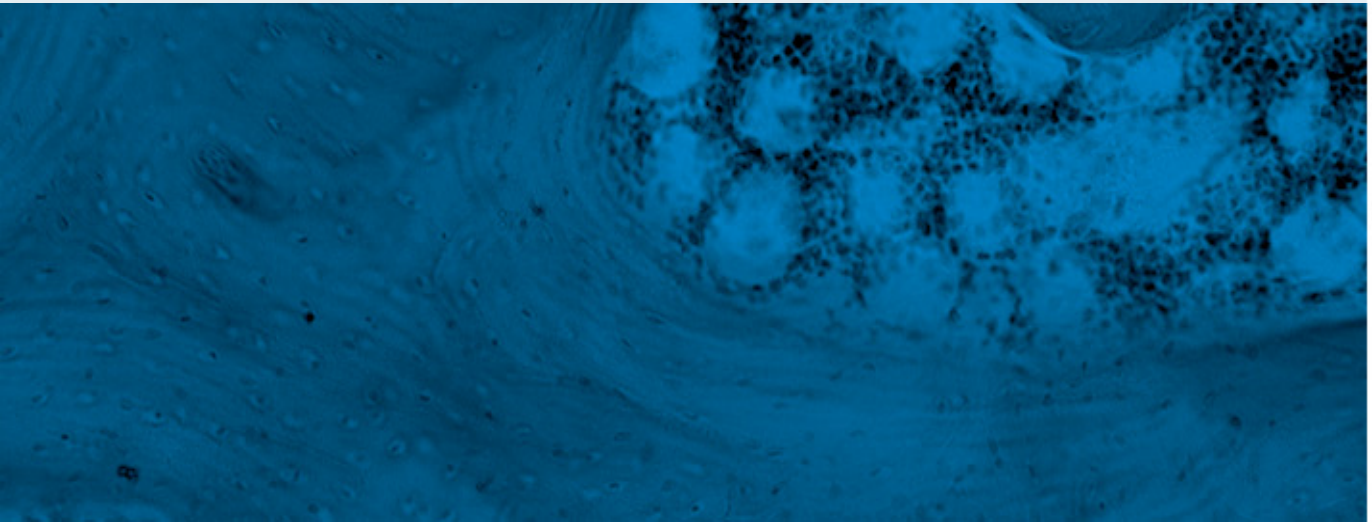
NASEM Committee on Implications of Discarded Weight-Based Drugs- Francis J. Crosson, M.D.



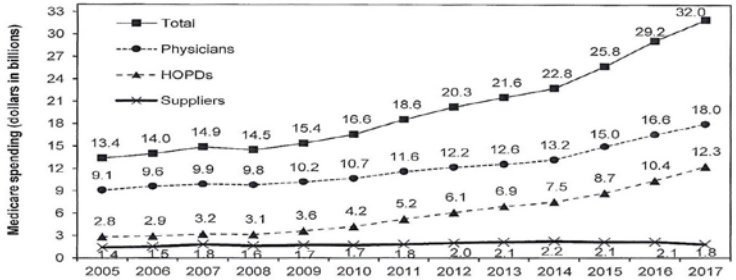


Agenda

- Overview of Medicare Part B drug costs
- Part B drug “buy and bill” payment process
- The roles of GPOs and distributors/wholesalers
- MedPAC proposed reform of the Part B drug payment process
- References

Medicare Part B Drug Spending 2005-2017

Chart 10-1. Medicare spending for Part B drugs furnished by physicians, hospital outpatient departments, and suppliers, 2005–2017



Note: HOPD (hospital outpatient department). Data include Part B–covered drugs furnished by several provider types including physicians, suppliers, and hospital outpatient departments and exclude those furnished by critical access hospitals, Maryland hospitals, and dialysis facilities. "Medicare spending" includes program payments and beneficiary cost sharing. Data reflect all Part B drugs whether they were paid based on the average sales price plus 6 percent or another payment formula. Data exclude blood and blood products (other than clotting factor). Components may not sum to total due to rounding.

Source: MedPAC and Acumen LLC analysis of Medicare claims data.

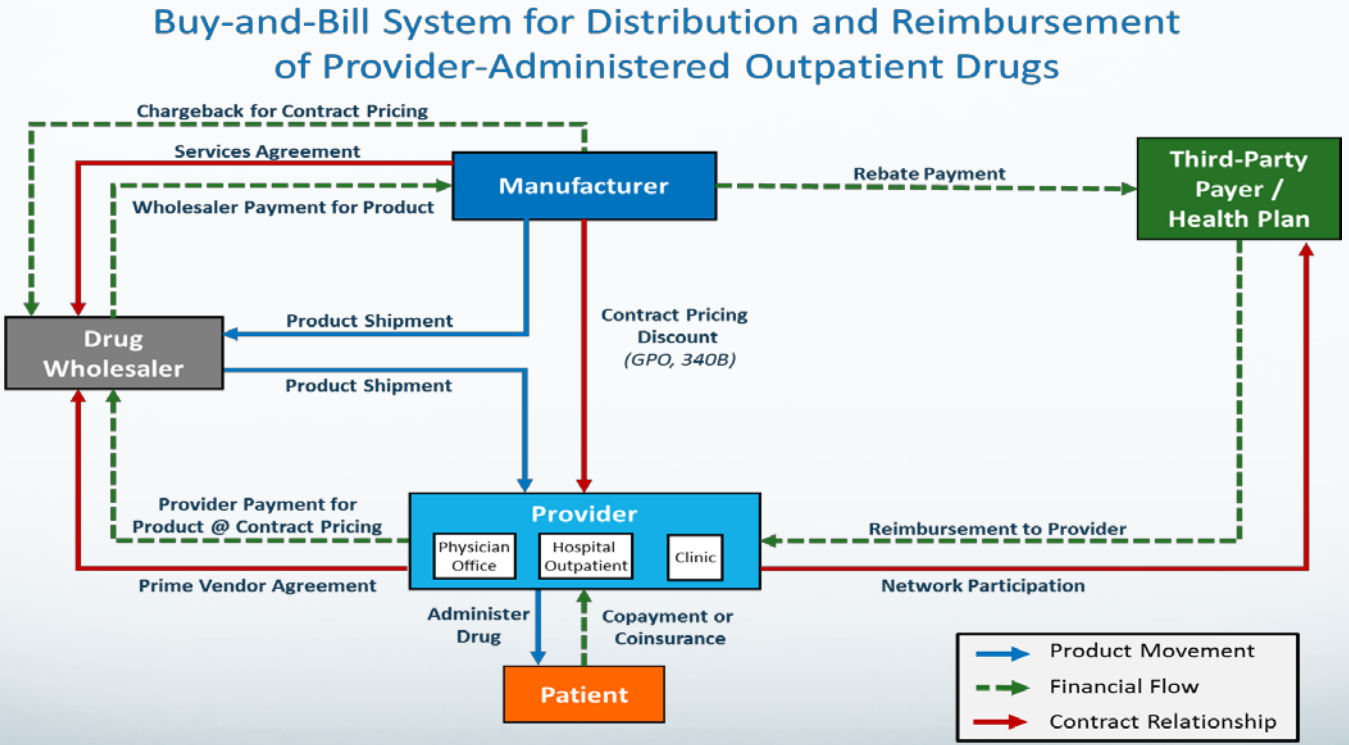
- The Medicare program and beneficiaries spent about $32 billion on Part B drugs furnished by physicians, suppliers, and hospital outpatient departments (HOPDs) in 2017, an increase of about 10 percent from 2016.
- Medicare's average sales price (ASP) payment system for Part B drugs began in 2005. Between 2005 and 2017, total spending grew at an average annual rate of 7.6 percent. Spending growth was slower from 2005 to 2009 (about 3.7 percent per year on average) and more rapid from 2009 to 2017 (about 9.6 percent per year on average).
- Of total 2017 Part B drug spending, physicians accounted for 58 percent ($18.0 billion), HOPDs accounted for 36 percent ($12.3 billion), and suppliers accounted for 6 percent ($1.8 billion).
- Between 2009 and 2017, Part B drug spending grew more rapidly for HOPDs than for physicians and suppliers—at average annual rates of about 17 percent, 7 percent, and 1 percent, respectively.

(Chart continued next page)

Top 10 Part B Drugs Paid for by Medicare in 2017 and International Price Comparisons

Product (Brand and Generic Names)	2017 Medicare Spend	U.S. vs. International Prices
Eylea (aflibercept)	2.47 Billion	1.7X
Rituxan (rituximab)	1.76 Billion	2.7X
Opdivo (nivolumab)	1.48 Billion	1.4X
Neulasta (pegfilgrastim)	1.40 Billion	3.2X
Remicade (infliximab)	1.35 Billion	1.2X
Prolia/Xgeva (denosumab)	1.24 Billion	4.6X
Avastin (bevacizumab)	1.07 Billion	2.0X
Lucentis (ranibizumab)	1.04 Billion	5.4X
Keytruda (pembrolizumab)	1.04 Billion	1.2X
Herceptin (trastuzumab)	0.79 Billion	2.2X

“Buy and Bill” System for Administered Drugs



GPO = Group Purchasing Organization; 340B = 340B Drug Pricing Program. Chart illustrates flows for **Provider-Administered, Outpatient Drugs**. Please note that this chart is illustrative. It is not intended to be a complete representation of every type of financial, product flow, or contractual relationship in the marketplace.
Source: Fein, Adam. J., *The 2016–17 Economic Report on Pharmaceutical Wholesalers and Specialty Distributors*, Drug Channels Institute, September 2016, Exhibit 28.
Available at http://drugchannelsinstitute.com/products/industry_report/wholesale/.

Current Medicare Part B Administered Drug "Buy and Bill" System

- Physicians and Hospital OPDs order, purchase and store drugs, usually from wholesalers/distributors
- After the drug is administered to a beneficiary, the provider bills Medicare (physicians must add JW codes)
- Medicare reimburses at 80% of volume-weighted Average Sale Price (ASP) + 4.3 % + an administration fee
- Providers collect coinsurance from the beneficiary- 20%, or Medigap (often via CMS); MA payment to provider varies by benefit design and specific plan-provider contract

The Role of Group Purchasing Organizations (GPOs)

- Largest: Premier, Vizient, HealthTrust, Intalere
- Purpose: to aggregate provider-purchasers, in order to use volume to negotiate lower prices from manufacturers
- Revenue sources: mostly-fees from manufacturers and distributors, as a percentage (3% maximum) of prices charged
- Do not take possession or title to the drugs

The Role of Distributors/Wholesalers

- Largest: AmerisourceBergen, Cardinal Health, McKesson
- Purpose: to consolidate drug sourcing and storage from manufacturers and then provide distribution services for drugs and related supplies as requested from provider customers
- Revenue sources: various manufacturer discounts, and incentive payments; fees from providers for certain services, e.g. analytics
- Do take possession and title to drugs

MedPAC's Statutory Mandate

- Established by Congress in the BBA-1997 as an independent advisory body to Congress
- Provides specific recommendations annually (in March) on payment rate updates to providers of services to Medicare beneficiaries
- Provides specific policy recommendations annually (in June) on Medicare structure and processes, access to care, quality of care, cost, and other issues affecting Medicare
- Seven public meetings a year; open to the public; proceedings recorded and transcribed to www.medpac.gov

MedPAC Part B Drug Payment Reform Proposal

- June 2017 Report to the Congress
- Modification of the current buy and bill model
- Improvement on the earlier CMS competitive acquisition program (CAP) model
- Make Part B more like Part D, sort of
- Congress to establish a voluntary “Drug Value Program” (DVP)

Drug Value Program (DVP)

- Medicare contracts with a small number of vendors
- Vendors negotiate for aligned providers
- Vendors are paid an administrative fee, plus an incentive based on Medicare savings; savings shared with providers; beneficiaries have lower OOP costs
- Vendors can employ a formulary, and, in certain cases, mandatory binding arbitration with manufacturers, e.g. single-source drugs with high launch prices
- ASP 4.3% “add-on” is reduced over time

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