The Medicare Program Could Save $11 Billion Over Five Years by Reforming Medicare Part B Drug Payment Policy

Spending on Medicare Part B drugs – which are administered by infusion or injection in outpatient settings to treat conditions such as cancer, macular degeneration, rheumatoid arthritis, and anemia – is growing at twice the rate of overall Medicare spending. From 2013 to 2017, Part B drug spending increased from $20 billion to $29 billion, growing 10 percent annually, while overall Medicare spending grew at 4.6 percent.[1] Assuming continued 10 percent growth, Part B drug spending will reach nearly $40 billion in 2020.

Medicare Part B Drug Payment

Medicare Part B drugs are paid for at "ASP plus 6," which is the market-wide average sales price for each drug plus a 6 percent variable add-on payment for the prescribing provider.[a] Consequently, providers' margins vary, increasing with the price of the drugs they prescribe. This can result in providers having an incentive to prescribe relatively more expensive drugs even when less expensive options with similar clinical effectiveness are available.[2,3,4,5,6,7] For example, according to peer-reviewed research and a 2012 HHS report, following implementation of the ASP plus 6 system, oncologists were more likely to prescribe high-priced cancer drugs instead of less expensive alternatives.[8,9]

The Savings Opportunity

Medicare program savings[b] can be achieved if physicians prescribe less expensive, clinically-effective substitutes for high-priced drugs. For example, if a physician who had been administering Lucentis – a biologic used to treat macular degeneration – were to substitute Avastin – a commonly used and less expensive alternative[10] – the price per dose would be 80 percent lower. Incentivizing the use of less costly substitutes by replacing the variable add-on payment with a single flat fee that is independent of a drug's average sales price would produce substantial savings.

Potential savings from implementing a single flat fee are illustrated in the table for ten drugs that represent 37 percent of total Medicare Part B drug spending. The savings assume an annual prescribing shift to less expensive substitutes of 5 percent, 7.5 percent, or 10 percent over the first five years the new flat fee is implemented. **Assuming a mid-range 7.5 percent annual prescribing shift, changes in physician prescribing behavior for the ten costly drugs could yield $11 billion in Medicare program savings from 2020 to 2024.**[c]

Medicare Program Savings Estimates: 2020 to 2024

Drug	Substitute	Savings and % Change, with Annual Volume Shift of: 5%	7.5%	10%
Eylea	Avastin	$3.3 B, 9.5%	$5.0 B, 14.2%	$6.7 B, 18.9%
Rituxan	Truxima	$0.4 B, 4.1%	$0.6 B, 6.2%	$0.9 B, 8.2%
Neulasta	Fulphila	$0.5 B, 5.1%	$0.7 B, 7.7%	$0.9 B, 10.3%
Remicade	Inflectra	$0.2 B, 2.9%	$0.4 B, 4.4%	$0.5 B, 5.9%
Prolia	Reclast	$2.3 B, 15.7%	$3.4 B, 23.6%	$4.6 B, 31.4%
Lucentis	Avastin	$0.3 B, 7.2%	$0.4 B, 10.7%	$0.5 B, 14.3%
Herceptin	Kanjinti	$0.2 B, 2.4%	$0.2 B, 3.6%	$0.3 B, 4.8%
Soliris	Ultomiris	$0.06 B, 1.4%	$0.09 B, 2.1%	$0.1 B, 2.8%
Epogen	Retacrit	$0.06 B, 4.8%	$0.1 B, 7.2%	$0.1 B, 9.5%
Aranesp	Retacrit	$0.1 B, 9.0%	$0.2 B, 13.4%	$0.2 B, 17.9%
Total		**$7.4 B, 7.8%**	**$11.1 B, 11.7%**	**$14.8 B, 15.7%**

[a] ASP is calculated based on each drug's volume-weighted, market-wide average sales price. The 6 percent add-on was reduced to 4.3 percent beginning in 2013 after Congress passed a 2 percent budget sequester.

[b] Savings to the Medicare program include savings to both the federal government and beneficiaries.

[c] A single flat fee that replaces the 4.3 percent add-on is calculated on a budget neutral basis for each year from 2020 to 2024. The fee would range from $22.45 in 2020 to $29.18 in 2024. Savings are based on the assumption that providers will switch to less costly substitutes once the variable payment incentive is removed, and that providers do not increase their overall volume to make up for potential lost revenue.

February 2020