Medicare to test cost-cutting plan for Part B prescription drugs

Kate Randall
12 March 2016

The Centers for Medicare & Medicaid Services (CMS) plans to test ways to pay for drugs under Medicare Plan B, which covers treatment in doctors' offices, clinics and hospital outpatient centers. The plan would target prices for many intravenous cancer medications, injectable drugs, certain eye treatments and other medications under Medicare, the government-run health insurance program for the elderly and the disabled.

In an announcement Tuesday, the CMS said the plan would "test new models to improve how Medicare Part B pays for prescription drugs and supports physicians in delivering higher quality care." Numerous oncologist and other physician groups have opposed the plan, saying it will adversely affect the care of vulnerable Medicare patients being treated for cancer and other complex conditions.

In a letter opposing the plan, the American Society of Clinical Oncology says that Medicare beneficiaries make up 60 percent of the 14 million Americans living with cancer. The group notes that elderly are 10 times more like to get cancer than younger people, and that their treatment involves careful consideration about which drugs to administer.

CMS argues that there are currently financial incentives for doctors to choose higher-cost medications, even in cases when less expensive drugs may be equally or more effective. Medicare pays outpatient doctors and hospitals the average selling prices of Plan B medicines plus 6 percent. Thus a provider will receive $60 for administering a $1,000 drug compared to $6 for a $100 medicine.

Under the first phase of the test plan, Medicare would get the average selling price of the drug, plus 2.5 percent and a flat fee of $16.80 per drug per day. Beginning in 2017, the proposal's second phase would test the effectiveness of reducing or eliminating patient cost-sharing to influence patients and physicians to "improve beneficiaries' access and appropriate use of effective drugs," i.e., to incentivize the use of those drugs with the "best value." The proposed rules will be open for comment through May 9 before being tested.

Medicare officials cite the skyrocketing cost of prescription drugs in the US—which rose to $457 billion in 2015, or 16.7 percent of overall health spending—as justification for moves to rein in spending. Medicare Part B spent $20 billion on drugs administered by physicians and hospital outpatient departments last year.

Outpatient providers, including some physicians, clinic and hospital outpatient operators, are undoubtedly influenced by the higher return on prescribing higher cost drugs. Under the for-profit delivery of health care in America, the care of patients is ultimately subordinated to these profit interests, with unscrupulous physicians groups and hospital chains benefiting financially by prescribing drugs and providing treatments that bring the biggest return.

This corruption is particularly prevalent in Medicare, a government-run insurance program that is beholden to the operations of the capitalist market. But the CMS is not motivated by concern over such provider practices. Rather they are seized upon to introduce arbitrary rules that will cut reimbursements for Medicare drugs with little consideration of how this will affect patient care.

CMS officials point to the rising costs of prescription drugs as justification for the new rules. For example, according to the *Journal of Oncology Practice*, before 2000 the average cancer drug price for one year of therapy was less than $20,000. By 2012, 12 of the 13 new drugs approved for cancer therapy were priced above $100,000 per year.

However, unlike the majority of other industrialized nations, in the US there is no governmental regulation on what drug companies can charge for their products. In January, according to figures compiled by the *Wall Street*

Journal, Pfizer, Amgen, Allegan, Allegan, Horizon Pharma and other drug makers have hiked US prices for dozens of branded medications, with many of the increases 9-10 percent over December 2015 prices.

This inconvenient truth about the for-profit health system in America is not addressed by the CMS proposals to reduce Medicare Plan B drug spending. Critics of the proposals note that drug companies may very well respond to the efforts to incentivize outpatient providers to use less-expensive drugs by raising their prices.

In a letter to HHS Secretary Sylvia Burwell and CMS Acting Administrator Andy Slavitt, more than a hundred physicians groups and patient advocacy organizations expressed their opposition to the Medicare Part B model proposed by CMS. Those signing included the American Society of Clinical Oncology, the Coalition of State Rheumatology Organizations, the National Infusion Centers Association and the National Association for Rural Mental Health.

The letter states: “We believe that this type of initiative, implemented without sufficient stakeholder input, will adversely affect the care and treatment of Medicare patients with complex conditions, such as cancer, macular degeneration, hypertension, rheumatoid arthritis, and primary immunodeficiency diseases.”

It notes that Medicare beneficiaries, who make up some of the oldest and sickest patients, must often try many drugs before finding the appropriate treatment, adding: “These vulnerable Medicare patients and the providers who care for them already face significant complexities in their care and treatment options, and they should not face mandatory participation in an initiative that may force them to switch from their most appropriate treatment.”

The letter also says that CMS is statutorily required to ensure that any initiatives target “deficits in care,” and can only be expanded in scope and duration after a careful assessment of “the model’s impact on quality of care, patient access, and spending.” Testing for the new Medicare Plan B model will be conducted among study and control groups based on ZIP codes or similar units rather than on units with perceived deficits in health care quality.

The letter to Burwell and Slavitt warns that under the proposed model, “Medicare beneficiaries with life-threatening and/or disabling conditions would be forced to navigate a CMS initiative that could potentially lead to an abrupt halt in their treatment.”

The proposed rule changes in the way drugs are paid for under Medicare Plan B are in line with the drive of the Obama administration to cut health care costs in general, and in Medicare in particular. More than 55 million Americans are currently enrolled in Medicare, and this population has greater health care needs due to age and disability, making them a prime target for cutting costs.

The Affordable Care Act (ACA), signed into law in 2010, far from making strides toward universal and high-quality medical coverage, in fact initiated a counterrevolution in health care. Its key component, the individual mandate, requires individuals without coverage through their employer or a government-run program such as Medicare to purchase coverage from private insurers under threat of tax penalty.

The least-expensive plans under the ACA come with high deductibles and other out-of-pocket costs, as well as narrow provider networks and restrictions on prescription drug coverage. The program popularly known as Obamacare is serving as a model for employer-provided coverage, which is steadily eroding through increased premiums and deductibles as well as cuts to provider networks and services covered.

Medicare was initiated a half-century ago as one of the last social reforms in the US, under conditions of intense crisis for American capitalism as the nation was gripped by the civil rights movement and militant struggles by workers for higher wages and improved social conditions. The latest White House proposal to cut Medicare Plan B prescription drug costs are in line with efforts aimed at undermining this social program.

While the Obama administration has sought to distance itself from Republican proposals to privatize Medicare, the general trajectory of its health care policy is in line with the drive by the most right-wing sections of the ruling elite to do away with Medicare as well as Social Security, the government-run retirement program.