INQUIRING MINDS MARCH 25, 2016
TOPIC: DRUG COSTS
MODERATOR: AL KAPLAN

While the title of this presentation and discussion is listed as Drug Costs, we would all be remiss in not acknowledging that Health Care Delivery in these United States, is a multi faceted and complex problem. Today we will deal with only one facet of this panorama.

The topic is perhaps more current today, because of the recently introduced possible changes in costing of drugs by the Obama Administration and the Medicare Payment Advisory Commission.

Two pertinent recent articles from the Media follow.
+++++++

US to test ways to cut high drug costs… NY Times. March 9, 2016

WASHINGTON — The Obama administration said on Tuesday that it would test new ways to pay for prescription drugs in an effort to slow the growth of Medicare spending on medicines while encouraging doctors to choose the most effective treatments for their patients.

The announcement comes as presidential candidates including Hillary Clinton, Senator Bernie Sanders and Donald J. Trump are calling for government action to protect consumers against high drug prices.

Federal officials said the government spent $20 billion last year under Part B of Medicare for prescription drugs administered in doctors' offices and hospital outpatient departments.

The current payment formula provides "weak incentives" for doctors to choose the lowest-cost therapy to treat patients effectively, the administration said. Indeed, it said, the current payment formula "may encourage the use of higher-price drugs when lower-cost drugs of equivalent effectiveness are available."

Medicare payments to doctors and hospitals for Part B drugs are generally based on the average sale price of a drug and 6 percent, officials said. The Medicare Payment Advisory Commission, an independent panel that advises Congress, said this formula "may create incentives for use of higher-priced drugs," because 6 percent of a higher-priced medicine generates more revenue and potentially more profit for health care providers.

Part B covers a wide range of drugs to treat various types of cancer, rheumatoid arthritis, macular degeneration and other conditions. Many are produced by genetic engineering or made from microorganisms or human or animal cells. Use of such "biologics" has grown rapidly in the last decade and now accounts for a majority of Part B drug spending, the administration said.

Dr. Patrick H. Conway, a deputy administrator of the Centers for Medicare and Medicaid Services, said the government would test a half-dozen alternative ways of paying for drugs under Part B of Medicare.

Under one proposal, Medicare would set a standard payment rate, or benchmark, for a group of "therapeutically similar drug products." Pharmaceutical companies have opposed this idea, known as reference pricing, because, they say, patients with the same condition may respond differently to the same drug.

Under another proposal, Medicare would pay drug companies based on how well their treatments work in patients. Payment might be linked, for example, to the effectiveness of a drug in preventing heart attacks.

Yet another option would reduce or eliminate the patient's share of the bill for Part B drugs. Currently, beneficiaries are often responsible for 20 percent of the Medicare-approved amount for outpatient drugs under Part B.

Medicare could also provide feedback to doctors, informing them how their "prescribing patterns" compare with those of doctors in certain geographic regions or in the nation as a whole.

Under another alternative, Medicare would reduce the 6 percent add-on payment to 2.5 percent and pay a flat fee per drug on top of that.

Dr. Conway said the government was not infringing on the discretion or authority of doctors.

"Physicians and clinicians will make the prescribing decisions," he said. "Nothing limits the ability of physicians to prescribe the most appropriate medications."

He could not say how many of the 55 million Medicare beneficiaries would be affected by the new methods of paying for prescription drugs. Different methods will be tested in different parts of the country, he said.

The administration said it would accept public comments on the proposals until May 9.

In an apparent effort to justify government action, the Department of Health and Human Services issued a new report on Tuesday. The report estimates that prescription drug spending in the United States totaled $457 billion in 2015, or 16.7 percent of spending on personal health care services. That is higher than previous official estimates because it includes not only retail drug spending, which was counted in prior government reports, but also spending on drugs administered in hospitals and doctors' offices.

Of the $457 billion in drug spending last year, the administration said, about $328 billion (72 percent) was for retail drugs, and about $128 billion (28 percent) was for drugs provided in hospitals and doctors' offices, often by injection or infusion.

++++
The headline…,Medicare tries an Experiment, the NY Times, March 10, 2016

Suppose you're an eye doctor and you're treating a patient with macular degeneration, a disease that can cause blindness. You have the choice of giving one of two drugs — one that costs $2,000 per treatment and another, very similar one, which costs $50 per treatment.

Do you think it would influence your decision if you were paid $117 more if you chose the more expensive drug?

That, essentially, is the system we have now. For doctors who give drugs in their offices, mostly cancer, eye and arthritis specialists, Medicare asks them to buy the drugs themselves and then pays them back when they give the drugs to patients. Currently, Medicare pays doctors the average sales price of the drug, and then tacks on a 6 percent bonus to cover their administrative costs. Obviously, 6 percent of $2,000 is a lot more than 6 percent of $50.

Doctors argue that they choose drugs based on what's most medically appropriate for their patients — and most probably do. (There are some good reasons a doctor might choose the $2,000 drug over the $50 drug for some patients.) But several analysts have looked at this policy and determined that it creates the wrong kind of incentives for doctors — encouraging them to choose pricier treatments even if they are no better than cheap ones.

Some studies have found evidence that the system has actually shifted doctors toward the more expensive drugs. President Obama has repeatedly proposed changing this policy in his annual budget, and the Medicare Payment Advisory Commission, which studies the program for Congress, has also suggested an end to the 6 percent premium.

On Tuesday, his administration took action on its own authority through the Affordable Care Act. Medicare announced that it would use those broad new powers to test out a new system, to see if reducing the financial incentives for prescribing expensive drugs might change the choices that doctors make. The agency is setting up a sort of randomized experiment, keeping the system intact for doctors in some parts of the country, while introducing a new payment method for doctors in a set of communities.

Doctors in the experimental places will no longer get paid 6 percent of the cost of the drug to cover their overhead. Instead they will get 2.5 percent of that cost, plus a flat fee, regardless of the price of the drug. Under the new system, the difference in payment for the expensive eye drug, Lucentis, will be less than $50 more than the cheaper alternative, Avastin.

Medicare isn't changing the direction of the incentive — there's no bonus for picking a cheaper choice — but it's narrowing the payment gap between different drugs. Peter Bach, an oncologist and the director of the center for health policy and outcomes at Memorial Sloan Kettering Cancer Center,

compares the new system to U.P.S.: We pay the company a fee for moving the box, but we don't pay different prices based on the value of the box's contents.

The Centers for Medicare and Medicaid Services, the government agency that runs Medicare, devised the new payments to be budget neutral. That means that it expects, over all, that Medicare will pay doctors the same amount through the lower percentage fees and the new flat administrative fees. But the change will clearly have effects for some individual physician offices. Doctors who prescribe a lot of newer, more expensive drugs will earn less than they used to. Doctors who already prescribe a lot of cheaper, older drugs may get a raise. Doctors who tend to pay above-average prices for drugs — like small, independent practices — may have more trouble covering the cost of certain drugs, and could run into financial trouble. Most community doctors and large hospitals, who treat a range of cancer types and thus prescribe both cheap and expensive drugs, should not see a huge change, the government estimates.

The proposal, which was accidentally published in draft form in February, has infuriated several groups of cancer doctors. They argue that there's not enough evidence of malfeasance in the current system to be worth the possible harms to doctors and drugmakers — and theoretically to patients.

The government is "proposing a mandatory experiment on seniors' cancer care," Ted Okon, the executive director of the Community Oncology Alliance, a trade group for small oncology practices, said in an email. "The policy regulators, without any supporting data, are, in effect, saying that seniors under Medicare are receiving inappropriate cancer treatment."

The pharmaceutical industry is also worried. Any policy that steers doctors away from newer drugs could cut into their sales. The lower margin on drugs will also make it harder for drugmakers to raise prices without hurting doctors. There's a time lag between when prices in the market shift and when the government starts paying those new prices. That means that, with a smaller percentage bonus, price increases could cause doctors to lose money on drugs while they wait for the Medicare price to catch up.

A later phase of the experiment is still in development, but it may give those parties more to worry about. Medicare officials suggested that they want to

test other methods that might punish doctors who use more expensive drugs if doctors can't prove they work better.

Before Obamacare, a payment change this large would have required new legislation. But the health law allows Medicare to introduce pilot programs and experiments, and expand them nationwide if they measure up. Earlier, such experiments were voluntary, but the drug pilot is one of a small number of tests that are now mandatory for doctors and hospitals who practice in certain parts of the country.

In abstract terms, the mandatory, regional design of the program makes it a great way to testwhether new payment incentives can lead to more rational, and perhaps less expensive, prescribing behavior. Over time, the government will be able to compare the spending and health outcomes for Medicare patients in the places testing the new policy with those who continue to use the old one. In the early years of the health law, critics were frustrated that the government was mostly using voluntary pilot programs in place of real experiments like this.

But the reality is that the change may have some negative consequences for certain doctors and hospitals whose payments will be cut.

"Does it make a ton of sense in theory? Yes. Is it a more rational payment system? Yes," said Caroline Pearson, a senior vice president at the health consulting firm Avalere Health. "But in the meantime, it causes a lot of disruption."