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Prioritize Doctors' Offices for Part B Drugs

— Congressional reform can benefit government spending and patients alike

by Madelaine Feldman, MD
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Medicare Part D is widely known as the program's pharmacy benefit, but Medicare also covers certain medications in Part B. Generally speaking, Part B covers drugs that are infused or injected by a medical professional. These medicines treat some of the most debilitating conditions treated by specialists in rheumatology, gastroenterology, ophthalmology, neurology, oncology, and more. In some cases, they are true miracle drugs and, not surprisingly, they are expensive.

For that reason, Part B drugs have attracted much interest from policymakers. Between the Obama and Trump administrations, there were three different proposals to change Part B drug payment, but none of these were ultimately implemented, in large part due to stakeholder concern about the impact on medication access for beneficiaries. However, there is one aspect of Part B drug spending that has remained relatively unexplored in the reform discussions -- the vast savings that Medicare could realize if it prioritized the most efficient delivery setting for these drugs: the physician's office.

Currently, there are three settings where patients may receive Part B drugs: a hospital outpatient department, their physician's office, or, for some medications, their home. Recently, an Employee Benefit Research Institute Issue Brief quantified the potential savings from eliminating the differentials between administration sites for non-oncology specialty drugs, finding that employers and their employees could save as much as 36%, depending on the medication. Similarly, in 2019, UnitedHealth found that administering specialty drugs outside of hospital outpatient departments could save $4 billion per year. To be clear, this is not an indictment of hospitals. Rather, the higher charges partially reflect the simple fact that a hospital is a far more expensive place to run than a physician's office. The physician's office is both the most cost-effective and the safest: it recently has been shown that there is a 25% increase in significant adverse events in patients receiving

biologic infusions at home compared with those receiving infusions at a facility, such as a physician's office.

Unfortunately, many past Part B reform proposals would have reduced access to the most efficient delivery setting by cutting physician reimbursement for administering these drugs. These types of reforms hit existing office-based infusion and injections the hardest because specialty practices do not have the margins to absorb these cuts. That's especially true for practices in underserved and rural areas. Congress must do precisely the opposite and expand beneficiary access to in-office administration. So far, proposals to reform Part B drug payment both from Congress and previous administrations have always focused on merely cutting reimbursement. It's the easier thing to do. It's also less likely to anger the hospitals, which any meaningful movement towards site neutrality or promoting in-office drug administration is sure to do.

When it comes to our country's drug affordability problem, prioritizing the most efficient site of care is not a panacea, but as specialty providers, we have no control over a drug's price or its quarterly price increases. What we offer to our patients and the Medicare program is a high-quality delivery setting at the lowest possible cost for Part B medications. That would reduce patients' out-of-pocket costs as well, which is a goal we all share. We hope Congress will focus on expanding -- not reducing -- access to that delivery setting in future reform proposals.

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