Coverage Shift from Medicare Part B to Medicare Part D
Issue Brief

Issue

The consolidation of Medicare Part B into Medicare Part D offers Congress the opportunity for entitlement savings, however, consolidation would likely result in restricted patient access and greater cost-sharing by beneficiaries. Prior to the introduction of Medicare Part D in 2006, outpatient drugs covered under Part B were those intended to be furnished “incident to a physician’s service,” used with durable medical equipment (DME), or statutorily mandated for Part B coverage. Since January 1, 2006, all other drugs administered in the outpatient setting have been covered under Medicare Part D prescription drug plans or Medicare Advantage plans. While the dividing line between Part B drugs and Part D drugs is often clear, there are many drug classes and many drugs, plasma protein therapeutics included, that have overlapping coverage between Part B and Part D.1 The coverage overlap adds administrative costs to the healthcare system because Part D plans are required by CMS to determine, through prior authorization, whether a drug with overlapping coverage should be covered under Part B and not Part D. The cost of the prior authorization process is most often born by pharmacists, physicians, and hospitals. Since 2006, this burden has attracted the attention of Congress, and is a likely target for physician and hospital special interest support, thus making consolidation of Parts B and D a likely tool for improving efficiency and creating savings through the deficit reduction process.

In addition to eliminating the ancillary costs of overlapping coverage, consolidation of Part B drugs under Part D would also produce savings by essentially expanding the cost utilization mechanisms that exist in Part D to Part B drugs. These Part D mechanisms include the power for private plans to negotiate for lower prices, manipulate demand through tiered cost-sharing, and restrict product availability in plan formularies. It is qualitatively evident that applying these Part D cost-utilization mechanisms would lower CMS expenditures for any Part B drugs shifted to Part D, adding to the sentiment for targeting consolidation through the deficit reduction process.

---

1 In their study contracted by the Medicare Payment Advisory Commission, the National Opinion Research Center in collaboration with Georgetown University, reported that there are approximately 6,000 drugs that could be covered under either Part B or Part D. Hargrave, Elizabeth, et al. Coverage and Pricing of Drugs That Can Be Covered Under Part B and Part D, Report to the Medicare Payment Advisory Commission, (2007).
PPTA Position

In finding efficiencies and opportunities for healthcare system savings, PPTA urges Congress to refrain from shifting plasma protein therapies from Medicare Part B to Medicare Part D and consider the following:

- Plasma protein therapies are non-interchangeable branded products;
- Because each brand produces unique pharmacokinetic and pharmacodynamic effects per patient, plasma protein patients rely on access to the full range of brands within a product class for safe and effective treatment;
- Subjecting plasma protein therapies to the restrictive formulary practices allowed under Medicare Part D could restrict patient access to safe and effective treatment by barring coverage of certain brands;
- Shifting plasma protein therapies into the Part D tiering structure would likely mean higher costs for plasma patients who suffer from life threatening and chronic illnesses.

In light of the risks to patient access and added financial burden to chronically ill patients, PPTA urges Congress to not shift plasma protein therapies from Medicare Part B coverage to Medicare Part D.