

Drug Pricing Lab Policy Brief

Competitive Acquisition Program

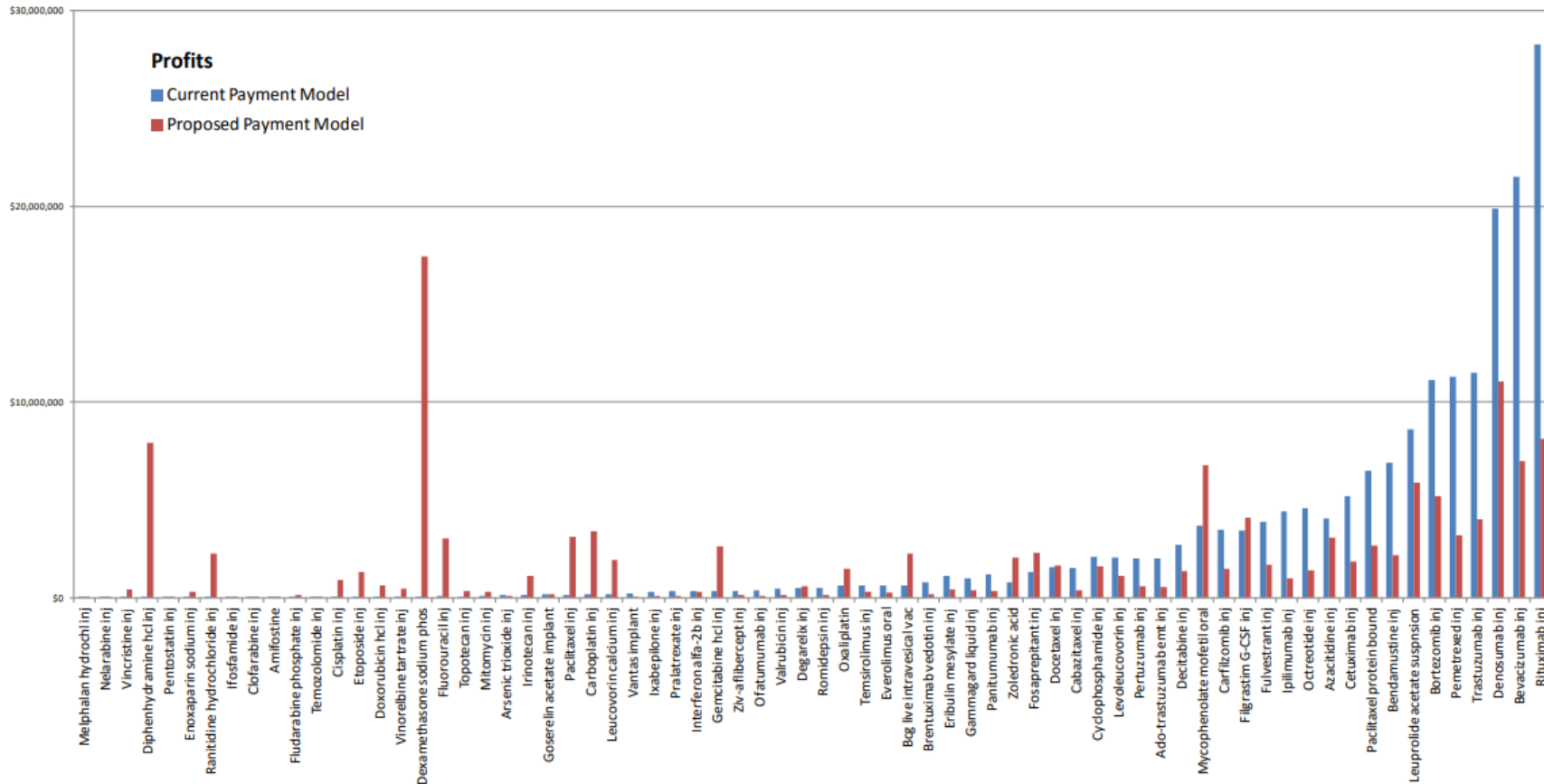
Peter Bach

President Trump's plan to address drug pricing includes a re-introduction of the Competitive Acquisition Program (CAP) first introduced in the [2003 Medicare Prescription Drug, Improvement, and Modernization Act](#). The key notion of CAP was to have a vendor to use its market leverage to bid for Part B (medical benefit) drugs and biologicals on behalf of provider. It would then send those to the provider on demand. The approach replaces the current buy-and-bill system, where individual providers purchase drugs and then bill for them at a mark-up after they are administered to the patient (106% of ASP). While the approach has several merits, its initial launch was not considered successful. Only a very small number of physicians and practices signed up, most were solo practitioners or practiced in two doctor offices. A detailed review is available [here](#).

The new proposal from the White House to revisit CAP does not yet have much detail, but it is worth reviewing a few of its features to keep an eye on.

- 1) **Potential to target the high leverage drugs:** While the initial roll-out of CAP required providers to either choose getting drugs from CAP or alternatively sticking with buy-and-bill, this is not required by the law. One possibility of certain categories of high cost drugs while leaving inexpensive drugs that are frequently used in buy-and-bill is that the CAP vendor could be charged with negotiating and acquiring a subset of Part B drugs, while leaving the remainder in Buy-and-Bill. This is a highly appealing wrinkle on the implementation. Most of spending on Part B is accounted for by a handful of high priced drugs. Likewise, a handful of drugs account for most of the profits providers earn due to the mark-up over ASP (Figure 1 based on 2014 data). This suggests that a route forward for CAP is to focus on just the highest priced drugs where the logistics are minor relevant.

Distribution of payments and profits for Part B drugs (2014). All of the 'action' is in the last several drugs.



- 2) **Potential to help small practices:** As was seen in the initial rollout of CAP, smaller practices often have trouble obtaining Part B drugs at an acquisition price below reimbursement. CAP would remove the problematic economics for them.
- 3) **Potential for negotiating lower prices:** [Secretary Azar](#) noted that the Part B program currently ‘takes prices’, meaning CMS reimburses drugs based on the reported sales prices of those drugs. CAP vendors could theoretically employ formularies and thus exert negotiating leverage over Part B drugs based on existing legislation. It is worth noting that there are political challenges of excluding particular expensive drugs from a formulary, which is the type of leverage a CAP vendor would need in order to obtain

lower prices. Also worth noting, [the law](#) on which CAP is based includes a provision that allows the Secretary to override the CAP vendor, an authority that could be subject to strong political leverage. Called the “EXCLUSION AUTHORITY”, it reads:

- a. *The Secretary may exclude competitively biddable drugs and biologicals (including a class of such drugs and biologicals) from the competitive bidding system under this section if the application of competitive bidding to such drugs or biologicals— “(i) is not likely to result in significant savings; or “(ii) is likely to have an adverse impact on access to such drugs or biologicals.*

- 4) **Potential to enable more sophisticated payment models:** At current scale, buy-and-bill prevents the more sophisticated approaches to payment that are contemplated in the Trump proposal, most of which have been previously published. This includes the ability to have [indication specific pricing](#). Having a drug travel in the market with two different prices, which is how indication specific pricing would work, requires separate bookkeeping and accounting for each dose, and have in place diversion protections. This is something a CAP vendor could accomplish, while very difficult for providers under buy-and-bill.
- 5) **Undoing the inflationary incentives of the 6% mark-up:** The administration has noted the problems with having a 6% mark-up for Part B drugs, and that it can lead to prescribing for more expensive drugs and can reach surprising levels when drugs are for instance \$400,000. The Drug Pricing Lab recently [reviewed the research](#) showing that providers are influenced in the direction anticipated by the mark-ups.