

the incentive to prescribe the lowest cost-effective alternative. Since under bundling physicians are given a flat rate for each episode, they have the financial incentive to utilize the lower cost drugs, which will increase their profit. Since many biologics are physician administered, bundling would be easily adopted for biologics. Physician confidence in biosimilar products will be determined through experience and use, brand reputation of biosimilars, as well as any educational efforts.

For patients, accountable care organizations (ACOs) may utilize reference pricing. Under reference pricing, the consumer has the incentive to use the lower priced biologics. They are paying out of pocket for the difference between the price of the drug they choose and the reference price. Under such a payment system, physician and patient incentives are aligned.

Similarly, the growth of ACOs, encouraged by the Affordable Care Act, where providers earn higher profits for cutting costs, would seem to encourage the use of biosimilars. Medicare has ACOs and is considering reference pricing and bundling. In the US market, third-party private payers will have the ability to negotiate the best deal for their clients. The biosimilar reimbursement market will likely develop similar to the present generic drug system, with the exception that the reference product will also compete on the basis of price. Manufacturers may have to compete for preferred formulary placement when choosing to enter the market. In the US market, third-party payers will have the ability to negotiate the best deal for their clients and may utilize a tier system. This tier system and copays will drive consumer choice in the biosimilars market. In the US, a bidding process for exclusive arrangements could be utilized to encourage more competition and might lead to more rapid expansion of biosimilars. The use of biosimilars could proceed faster than the experience in the EU and other developed markets. The experience with generics and the higher US prices of biologics would provide support for that possibility.

One model may be evolving from the recent controversy over the price that Gilead has been charging for its hepatitis C drug, Sovaldi. Even though it is not a biologic, Sovaldi was priced at \$84,000 for a course of treatment, which raised concern among payers. AbbVie came out with a newly approved hepatitis C drug, Viekira Pak. Express Scripts negotiated a discount for Viekira Pak and entered into an exclusive agreement. It will be the only hepatitis C drug in the Express Scripts formulary. In response, CVS signed an exclusive agreement for a discounted Sovaldi (Harvoni). These arrangements could be employed in the biological markets to encourage greater uptake of biosimilars.

16.26 MEDICARE

Medicare spends billions of dollars on biologics each year, with these expenditures increasing every year. Medicare reimburses biologics under both Parts B (practitioner administered) and D (normal prescribed drugs), but more prominently under B because biologics are usually infused or injected by health practitioners. In 2010, 8 out of the top 10 Medicare Part B drug expenditures were biologics and totaled \$8 billion (GAO, 2013). The reimbursement markup for biosimilars is 6% of the selling price of the reference product, so that the physicians receive the same monetary