

# Committee on Ways and Means

## Medicare Prescription Drug and Modernization Act of 2003

### *Reimbursement for Part B Drugs: Average Wholesale Price Reform*

Recently (June 16, 2003), MedPAC's biannual report to Congress noted the system for reimbursing currently covered Part B drugs is seriously flawed.

- Spending is growing rapidly at double digit rates for these drugs. MedPAC estimates spending increased 35 percent between 2001 and 2002.

MedPAC identified three problems with the current system:

- Medicare payments estimated at \$8.5 billion in 2002 "far exceed" the cost providers incurred to acquire the drugs.
- The system creates incentives for manufacturers to raise their list prices.
- Third, "drug administration fees do not reflect the true costs of providing drugs to beneficiaries."
- The Department of Health and Human Services Office of Inspector General (OIG) estimated that in 2000, Medicare beneficiaries paid \$177 million in unnecessarily inflated co-payments for physician-administered drugs.
- Medicare overpays for all Part B drugs by over \$1 billion annually (OIG and General Accounting Office (GAO)).
- Oncologists collected approximately \$700 million in overpayments for drugs (Congressional Budget Office (CBO) and Center for Medicare and Medicaid (CMS) actuaries).

### **Current Reimbursement Methodology**

Currently, drugs are reimbursed at 95 percent of the Average Wholesale Price (AWP). AWP is not defined by law or regulation. AWP's are reported by drug manufacturers to organizations that publish the data in compendia, which are used by Medicare carriers in calculating payment for Medicare covered drugs.

AWP's do not reflect the actual price paid by purchasers. The AWP for a product is often far greater than the acquisition cost paid by suppliers and physicians, due to a variety of rebates and other discounts made available to physicians by manufacturers. This "spread" between acquisition cost and reimbursement causes Medicare to overpay for drugs by about \$1 billion annually (OIG and GAO).

## **Proposed Reforms**

- Each year, physicians would select a reimbursement methodology, either Average Sales Price (ASP) or a new competitive bidding structure.
  - Competitive bidding would provide a new, innovative model to ensure physicians will maintain access to the therapies required for their patients.
  - Physicians would write a prescription; this script would be filled by a Medicare-contracted supplier that would then dispense the product to the doctor on a timely basis. Medicare would guarantee the availability of at least two contractors available in each region.
  - Oncologists would deliver the prescribed drug necessary for the patient, when the patient is seen by the physician.
  - The supplier, not the physician, would be reimbursed by Medicare. The supplier would be responsible for collection of the 20% co-insurance on the drug payment, lowering the bad debt exposure for physicians' practices.
  - Medicare would set standards for service and solvency, shipment and delivery, responses to physician inquiries, and establish a grievance process to resolve disputes, in addition to new and enhanced measures to prevent counterfeit or adulterated drugs.
- Or physicians could choose to be reimbursed at ASP, which is an average of all final sales prices in the U.S., net of rebates, discounts or chargebacks.