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U.S. House of Representatives

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June 19, 2003

Help End the Tax on Cancer Patients

Dear Colleague:

The Medicare program currently covers some drugs, limited principally to those that are administered incidentally to a physician's services (prescriptions such as chemotherapy infusions) or in conjunction with covered durable medical equipment. Since 1997, health care providers who administer these drugs have been reimbursed at the Average Wholesale Price (AWP) minus five percent. Of this amount, Medicare Part B covers 80 percent of the cost, and Medicare beneficiaries are required to pay the remaining 20 percent as a co-payment.

The AWP is not defined by law or regulation, but instead is reported by drug manufacturers to organizations that publish the data in compendia. AWP, however, is fiction and does not reflect an actual price paid by purchasers. For many products, the AWP often far exceeds the acquisition cost paid by physicians.

Unfortunately, cancer patients and other beneficiaries must pay their 20 percent coinsurance on the inflated price of the drug. This cancer tax is an unnecessary burden on our most vulnerable patients. The U.S. Department of Health and Human Services Office of Inspector General (OIG) estimated that in 2000, this tax resulted in \$177 million in increased costs to patients. The OIG and the General Accounting Office (GAO) estimate annual overpayments for these drugs at over \$1 billion. Oncologists received overpayments on drugs of approximately \$700 million, according to both the Congressional Budget Office and the Centers for Medicare and Medicaid Services (CMS) actuaries.

Physicians assert that the overpayment for drugs covers underpayment for practice expenses associated with providing care in outpatient settings. We want to change that by appropriately paying for physician services and the drugs they administer.

H.R. 2473, the "Medicare Prescription Drug and Modernization Act of 2003" includes reforms that will end this tax by eliminating the overpayment on drugs. At the same time, the bill would increase reimbursements for expenses incurred by physicians when delivering cancer care. It directs CMS to use the oncologist's own data on their practice expenses when computing reimbursements for cancer care services. It also directs CMS to expedite review of the codes that all physicians use to bill for administering drugs. In this way, we provide relief to cancer patients and assure the continuation of the high quality community oncology care that has been developed for Americans. (A summary of the provision in H.R. 2473 is printed on the back of this letter).

We strongly believe the bill would enhance and improve the access to quality care for cancer patients while significantly lowering the cancer tax patients pay on inflated drug prices. As CMS Administrator Tom Scully testified before Congress, "it is clear that the payment system for selected outpatient drugs that are now covered by Medicare is a mess." We must fix this problem while maintaining the best, most advanced system of care for cancer patients. As part of H.R. 2473, we will make this change.

We need to end this abusive practice to protect patients from the high costs of these drugs.

We encourage you to protect cancer patients and vote for H.R. 2473 when it comes to the House floor for your consideration.

Best regards,


Bill Thomas
Chairman


Nancy L. Johnson
Chairman
Subcommittee on Health

Enclosure

(MORE)

Summary of Provision in H.R. 2473, the "Medicare Prescription Drug and Modernization Act of 2003"

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 - Drugs

- Each year, physicians would select a reimbursement methodology, either Average Sales Price (ASP) or a stock replacement structure.

Stock Replacement

- The supplier, not the physician, would be reimbursed by Medicare. The supplier would be responsible for collection of the 20 percent co-insurance on the drug payment, lowering the bad debt exposure for physicians' practices.
 - 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.
 - Physicians would administer the prescribed drug necessary for the patient.
 - 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 charge backs.

Proposed Reforms - Physician Payment

- Under both systems, all oncologists would receive an increase in their practice expense reimbursements, based on their own survey data. Because they use the same billing codes, other specialties (e.g. urology, internal medicine) would also have their reimbursements increased. Specialties in the non-physician work pool would be held harmless, so their reimbursements do not decrease as a result of the oncologists coming out of the pool.
- In addition, CMS would be directed to expedite consideration of billing codes used by oncologists, and other specialties administering affected drugs.
- Doctors who chose the competitive bidding structure would receive an additional payment to reflect any increased administrative costs associated with the proposal.

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