

- For two high expenditure drugs provided by pharmacies, ipratropium bromide and albuterol, discounts from list AWP averaged 78 percent and 85 percent, respectively. In other words, suppliers paid 15 and 22 percent of the list AWP.

- While physician practices that purchase large volumes of drugs may have access to larger discounts and rebates, low volume providers can also purchase drugs for markedly less than list AWP, and often at additional discounts below widely available prices. In particular, physicians who bill Medicare for low volumes of drugs used in cancer treatment receive discounted prices for many of these drugs similar to or greater than widely available discounts. (See Table 2 in Appendix A for a reprint of the table from the GAO report summarizing some of these findings.)

- Private health plans use their drug-purchase and patient volume to negotiate favorable prices for drugs and the physician and supplier services related to supplying or delivering the drugs.

- Public payers, such as the VA, use their purchasing volume along with information about actual transaction prices from private payers to lower their drug payments.

Based on its studies, the GAO concluded that our current payment methodology is flawed because current payment rates (that is, 95 percent of the list AWP) do not reflect market prices. The GAO recommended that we take the following actions with regard to the payment for drugs and related services.

- Establish Medicare payment levels for Part B drugs that are more closely related to their costs. Payments for drugs should be set at levels that reflect actual market transaction prices and the likely acquisition cost to providers.

- Pay appropriately for drug delivery and administration and not allow potential overpayments for drugs to subsidize payments for related services.

- Examine the benefits and risks of expanding the current competitive bidding demonstration projects for drugs covered under Part B.

- Institute a process to monitor access to Part B covered drugs to ensure that payment changes do not negatively affect access for particular drugs or groups of beneficiaries or for certain geographic areas.

#### *F. Implications of GAO and OIG Studies*

Table 4 provides a summary of the reports on Medicare prescription drugs published by OIG between 1997 through 2001. The 1997 report indicated that for 22 drugs studied by the OIG, Medicare's

allowances for these drugs exceeded wholesale prices by \$447 million in 1996. For 1998 the report indicated that Medicare would have saved \$1 billion if the allowed amounts for the 34 drugs studied were equal to prices obtained by the VA through the Federal Supply Schedule (FSS). Additionally, the report indicated that Medicare would have saved \$1.6 billion for 24 drugs studied if Medicare had paid for these drugs based on the FSS. Although the savings estimates vary, for example due to differences in the particular drugs studied, OIG concluded based on the reports that the potential savings for Medicare and its beneficiaries from reforming the current payment policy to a system based on FSS is substantial.

In table 3, we have combined the findings of the GAO and OIG reports displaying the prices that they found as a percent of list AWP. For the GAO report, we used the findings from their widely available drug prices. We examined but did not use the separate survey of low volume billers. Although many low volume biller prices were below the widely available drug prices, they were compiled through a small phone survey of physicians. The widely available drug prices were based on price lists from wholesalers and GPOs. We believe that the widely available drug prices are a better reflection of the prices available to physicians and suppliers. In addition, there was much more consistency between the GAO's widely available drug prices and the OIG's finding.

Table 3 separately presents the findings for brand name drugs and for generic drugs. The "spread," computed as a percent of Medicare's payment at 95 percent of list AWP, is also displayed for each drug based on the average of the GAO and OIG findings. The lower the price found by GAO or OIG as a percent of list AWP, the larger the spread between that price and Medicare's current payment. In effect, the "spread" is the difference between the Medicare allowed charge (95 percent of the list AWP) and the actual purchase price paid by the physicians and suppliers. The percent spread is the difference between the Medicare payment and the market price expressed as a percentage of the Medicare payment. For example, the list AWP for granisetron hcl (J1626) is \$19.52. The Medicare payment is 95 percent of the list AWP or \$18.54. The average of the GAO and OIG data indicates that the market price is 71 percent of the list AWP or \$13.86. The 25 percent spread is calculated as  $(\$18.54 - \$13.86) / \$18.54 = \$4.68 / \$18.54 = .25 = 25$  percent.

A review of Table 3 shows that in general the "spread," in percentage terms, is larger for the generic drugs examined in the studies than for brand drugs. This is consistent with our understanding that when actual market prices decline with the introduction of generic competition, the list AWP's do not usually experience a corresponding decline of the same magnitude. With one exception, among the brand name drugs studied, physicians and suppliers could obtain these drugs at 71 percent to 87 percent of list AWP, which translates into a spread of 25 percent and 8 percent, respectively. For the generic drugs examined, there was considerably more variability. For six of the drugs examined, physicians or suppliers could purchase at a price between 15 percent and 46 percent of list AWP, translating into a spread of 84 percent and 52 percent, respectively. The other three drugs examined had spreads more in line with that for brand drugs.

A general conclusion reached in reviewing the GAO and OIG data is that there is a level of overstatement in the list AWP for all drugs beyond the 5 percent currently accounted for in Medicare's policy. Using the average of the GAO and OIG findings, every drug studied was available at a price not greater than 87 percent of list AWP. Most drugs could be obtained at an even lower price, sometimes substantially lower.

If we examine the data in the aggregate, the difference between Medicare's payment and widely available market prices was \$1.5 billion in 2002 for the 29 drugs where we have GAO and OIG data. That is, if Medicare had paid widely available market prices instead of 95 percent of list AWP in 2002 for these 29 drugs, Medicare and its beneficiaries would have paid nearly \$1.5 billion less for drugs or nearly 17 percent less than total estimated payments of \$8.4 billion. Of this amount, Medicare and its beneficiaries would have paid approximately \$475 million less to oncologists and \$760 million less to suppliers of DME drugs. Assuming that widely available market prices were between 80 percent and 90 percent of list AWP for all other drugs, the total savings to Medicare and its beneficiaries in 2002 from paying in this way would have been between \$1.7 and \$2.0 billion.

## **II. Provisions of the Proposed Rule**

### *A. Approaches to Revising the Current Payment System*

Given the serious and well-documented flaws in the current