

Medicare payment system identified by the GAO, OIG, and our own analyses, we are seeking comments on four different approaches to revising the Medicare drug payment system: (1) Basing our reform efforts on the comparability provision in the statute; (2) applying an average list AWP discount to the list AWP as of April 1, 2003; (3) utilizing existing sources of market-based prices and developing additional sources for market monitoring; and (4) establishing a competitive acquisition program and Average Sales Price system. We are proposing to select one of these options.

Option 1—Comparability Provision

One option we are proposing is to base our reform efforts on the “comparability” provision in the Act, section 1842(b)(3)(B) of the Act. Specifically, this provision limits Medicare payment for a drug to what our contractors pay when the same drug is provided to their private policyholders and subscribers under comparable circumstances. As described below, we are proposing additional guidance to our contractors in identifying comparable circumstances with respect to the drug payments they make in their private sector business. While comparability applies to all charge-based services, we are proposing to focus its application on drugs given the excessive payments by the Medicare program and our beneficiaries under the current methodology, as reflected in several OIG and GAO reports.

Section 1842 of the Act authorizes us to enter into contracts with carriers for the administration of Part B benefits. Section 1842(b)(3) of the Act mandates that each contract with a carrier provide that the carrier:

“ * * * will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to policyholders and subscribers of the carrier * * *.”

Section 1842 of the Act sets forth general provisions applicable to part B payment determinations, including drug payments. The comparability provision requires a carrier to take action, when necessary, to ensure that Part B charges are reasonable and “not higher than the charge applicable for a comparable service in comparable circumstances” to its own policyholders. This limitation is a principle set forth by the Congress at the outset of the Medicare program, providing that Medicare beneficiaries should not be charged more than private pay patients for a comparable service

provided under comparable circumstances. To this end, the Congress mandated that, where payment for a service to a Medicare beneficiary is on a charge basis, as opposed to a cost basis, the carrier’s private plan, if it has one, should be assessed to determine whether the service in question and the circumstances under which the service is provided are “comparable” to Medicare. If the service is comparable, then the applicable charge under the carrier’s private insurance plan may serve as a limitation on the amount that we pay. In accordance with these provisions, we have broad authority to make comparability adjustments with respect to Part B payment determinations based on charges.

At the time the Congress legislated the current drug payment methodology, it did not amend our authority to make comparability adjustments or provide any indication that the other provisions of section 1842(b) of the Act with respect to Part B payment calculations were no longer applicable.

Section 1842(b)(3) of the Act requires carriers, including Durable Medical Equipment Regional Carriers (DMERCs), to limit payment rates for Medicare covered drugs to the amounts that the carriers pay when these drugs are provided to their private policyholders and subscribers under comparable circumstances. We are proposing to issue additional guidance to our contractors indicating that comparability would exist with drug payments made in the same geographic area under the carrier’s indemnity health insurance products or broad network preferred provider organization (PPO) products that do not rely on selective contracting. We are seeking comments on this proposed guidance.

Consistent with § 405.508(c), the responsibility for determining that a carrier’s indemnity product or PPO product is comparable would in the first instance fall upon the carrier in reporting pertinent information about its programs to us. When the pertinent information has been reported, we will advise the carrier whether any of its products has comparability. If we determine that a carrier’s lower private payment for a drug has comparability in a given locality, the lower private payment limit would apply to the Medicare payment in that locality.

Contractors would inform physicians, suppliers and other impacted parties about the new lower payment limit through their usual means of provider education (for example, bulletins, newsletters, Web site postings.)

As an example of how this approach would apply to a specific drug using

hypothetical data, we will examine docetaxol (J9170). Suppose the national payment limit for docetaxol in 2004 was \$358. If one of our carriers was paying \$325 for docetaxol in one of its localities in its comparable private side business, the Medicare payment limit for docetaxol in that locality would be set at \$325. This lower payment amount would only apply in that locality and would not be the national payment limit. If, however, the carrier was paying \$375 for docetaxol in this locality, the Medicare payment would be based on the current national limit of \$358.

We understand that to the extent private sector drug payments vary by geographic region, the application of comparability may result in regional variation in drug payments. We seek comment on this aspect of the policy.

It is our understanding that historically many private insurers have focused more on payments for oral drugs and inhalation drugs than injectable drugs, although this is changing due to the rapid growth in expenditures for injectable drugs. MedPAC discussed this in their June 2003 report to Congress titled “Report to the Congress: Variation and Innovation in Medicare,” which stated that “Only as expenditures have sharply increased in the past few years have payers begun to focus on more efficient methods of paying for these drugs.” We are seeking information on these new methods of paying for injectable drugs and comments on any implications for Medicare drug payment limits under the comparability provision.

Option 2—Average AWP Discount

a. Existing Drugs

Another option we are proposing is to apply an average AWP discount to the AWP published in commercial compendia as of April 1, 2003. Specifically, we would lock-in and reduce the AWP published as of April 1, 2003 in the national drug pricing compendia by an average price discount from AWP. Our analysis of the available data from the GAO and OIG studies indicates that the majority of drugs examined had a discount of approximately 10 to 20 percent off of the AWP, with the remaining drugs having larger discounts. The Medicare payment limit, therefore, would be set at between 80 percent and 90 percent of the AWP published as of April 1, 2003. We are seeking comment on the appropriate uniform reduction to make in this range. This policy would be effective January 1, 2004. In future years, these prices would be updated on an annual basis by the increase in the consumer price index for medical care