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One Pill, Many Prices: Variation in Prescription Drug Prices in Selected Government Programs

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OVERVIEW — *This paper updates a June 2002 National Health Policy Forum Issue Brief, "Average Wholesale Price for Prescription Drugs: Is There a More Appropriate Pricing Mechanism?" Since the release of that paper, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, which created a new, comprehensive outpatient prescription drug benefit and reduced Medicare's reliance on the average wholesale price (AWP) in paying for prescription drugs. This paper discusses the continued use of AWP as well as other pricing benchmarks that pertain to prescription drugs. It explains the relevance of these pricing mechanisms to different government programs and sets forth some of the issues that have arisen in their use. The paper also contains a glossary of commonly used drug pricing terms, as well as an appendix that lists state Medicaid drug payment formulas.*

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Despite a recent decline in the rate of growth in drug spending, prescription drugs remain one of the fastest growing components of health care expenditures. The rise in prescription drug expenditures has been driven by several factors: increased utilization; the substitution of newer, more expensive drugs for less expensive drugs; and price increases for existing drugs.[1] State and federal governments—as major payers through Medicare, Medicaid, the U.S. Department of Veterans Affairs (VA), and other smaller programs—have a strong interest in controlling the growth in prescription drug spending. In 2004, the Medicaid program alone had annual outpatient drug expenditures of $30.6 billion, making it the single largest payer of prescription drugs in the United States.[2]

Overall prescription drug spending, which is determined by the volume and mix of drugs purchased and the prices paid, reached $162.4 billion in 2002 in the United States.[3] In their continued efforts to rein in drug spending, payers have targeted utilization and price in their cost-containment efforts. To shift utilization to less expensive drugs, for example, payers have implemented preferred drug lists; promoted the use of generic drugs; required prior approval for the dispensing of costly drugs; required step therapy, or the use of less costly drugs before more expensive alternatives may be prescribed; and utilized different forms of cost sharing to entice individuals to use lower-cost drugs. These techniques often help payers establish the leverage they need to negotiate better rebates or discounts, thus bringing down their net spending for prescription drugs. In addition, public payers have modified their drug reimbursement formulas to control drug spending. Congress and various state legislatures have also explored the possibility of changing the benchmark prices used by state Medicaid programs in determining drug reimbursement amounts.

PRESCRIPTION DRUG PURCHASING: AN OVERVIEW

In order to understand the attempts of payers to contain prescription drug spending, it is important to have an understanding of the variation in drug prices among these payers. Yet determining the net amount actually paid for a drug can be difficult because the entities that distribute the drugs are often distinct from the entities negotiating the payments and discounts.

Prescription drug distribution involves a chain of sellers and buyers that may include the manufacturer, a wholesaler, and a retail or mail-order pharmacy, although some pharmacies purchase directly from the manufacturer.[4]

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Each entity in this chain has possession of the drug that will ultimately reach the patient, and each entity receives a payment for the drug. The payment chain may involve additional entities. If the patient is insured, the insurer—or more typically, the insurer's representative, such as a pharmacy benefits manager (PBM)—will negotiate the price paid to the pharmacy. This price may reflect previous price negotiations between the PBM and the manufacturer. If so, then there may be subsequent price adjustments between the manufacturer, wholesaler, and pharmacy, termed "chargebacks."

In addition to negotiating the payment, a PBM typically will negotiate rebates or other price concessions from the manufacturer. These price concessions are based on the volume of patients for whom the PBM is negotiating as well as the PBM's ability "to move market share." That is, if the PBM can guarantee a manufacturer that its clients will prefer that manufacturer's drug instead of another one, it will receive deeper price concessions than would be achieved through volume alone.

One of the most widely used benchmark prices is the average wholesale price, or AWP.

All of these price concessions are passed from the manufacturer to the PBM. The extent to which they are, in turn, passed on to the insurer is not known.[5] Patients who purchase drugs without the benefit of insurance typically pay the pharmacy a higher price, termed the "usual and customary" price, than their insured counterparts.

Government and other payers generally establish their payment for prescription drugs through formulas that start with a benchmark price, some of which are proprietary and, therefore, not publicly available. For example, a particular state may set its Medicaid reimbursement rate at a benchmark price minus a certain percentage. In addition, some payment rates are subject to defined limits.

One of the most widely used benchmark prices is the average wholesale price, or AWP. Although not defined in law or regulation, AWP is intended to represent the average price at which wholesalers sell drugs. AWP is based on information provided by drug manufacturers, distributors, and other suppliers and sold by commercial publishers of drug pricing data, such as First DataBank and Thomson Medical Economics.

The AWP has often been equated with a "sticker price" or "list price," terms used in the automobile industry (for example, the sticker price for a new car); it is not a price that is paid, nor is it an average of any set of prices. It has been the subject of extensive criticism for the manner in which it is reported and for its failure to reflect actual prices paid in the market. It is intended to represent the drug price for transactions between wholesalers and purchasers, yet it is reported by manufacturers and may not take into account all of the discounts and rebates negotiated between the parties in such transactions.

Government pricing formulas may vary based on the type of drug, such as whether it is brand name or generic. The prices paid by government payers and purchasers vary across programs and are determined by different

FIGURE 1
Illustration of Relative Drug Prices Used by Select Government Payers

Source: Adapted from U.S. Government Accountability Office, "Prescription Drugs: Select Government Payers and Prices," PowerPoint presentation at "Understanding Medicare and Medicaid: Fundamentals and Issues for the New Congress" briefings by the National Health Policy Forum, January 13 and 14, 2005; available at www.nhpf.org/M&M_E.brief.book/session10/Dummit.pdf.

rebates and discounts that are defined in statute, in addition to negotiations with drug manufacturers (Figure 1).[6] Through various legislative vehicles, government programs have tried to mimic the action of the private market by obtaining price concessions outside the distribution chain. Discounts at the pharmacy and price concessions from manufacturers are often based on those obtained in the private sector.

Government payers use several benchmarks other than AWP to gauge the prices and discounts being negotiated in the private sector and, in some instances, to set limits on the prices they will pay. The MMA compels the Centers for Medicare & Medicaid Services (CMS), to collect proprietary data from manufacturers to calculate the average sales price (ASP), used for drug payment under Medicare Part B (the Supplementary Medical Insurance program of Medicare). The manufacturer also supplies to CMS the average manufacturer price (AMP) and best price for use in the Medicaid Drug Rebate Program.[7] The AMP and best price are considered proprietary and are not publicly available. In contrast, the federal supply schedule (FSS) price, which is used by federal purchasers such as the VA, the Department of Defense, and the Public Health Service, is available to the public. The FSS is negotiated by the VA and is based on prices charged to manufacturers' most favored commercial customers. (For more complete definitions of these and other key drug pricing terms, see the Glossary at the end of this paper.)

MEDICAID

Prescription drugs are a rapidly growing component of overall Medicaid spending. Medicaid expenditures for prescription drugs doubled between 1998 and 2002, and quadrupled since 1992. Between 2000 and 2002, Medicaid drug spending increased at an annual average rate of nearly 19 percent. In 2002, prescription drugs accounted for 11.3 percent of Medicaid expenditures.[8] Outpatient drug expenditures for the Medicaid program hit an all-time high of $30.6 billion (after rebate) in 2004. Key to state efforts to control Medicaid spending, therefore, are strategies to reduce prescription drug expenditures.

All state Medicaid programs offer prescription drug coverage to their Medicaid enrollees even though it is an optional benefit.[9] States are given substantial flexibility in the design of their prescription drug benefit, including the development of the methodology for reimbursing pharmacies. Medicaid program payments to pharmacies for outpatient prescription drugs typically include two components: (*a*) payment for acquisition costs, which covers the drug itself, and (*b*) a dispensing fee for the costs of filling the prescription.

In 2004, states received rebates on prescription drug spending of $9.2 billion through the Medicaid Drug Rebate Program. Some states negotiate supplemental rebates from manufacturers in addition to rebates from drug manufacturers under the Medicaid Drug Rebate Program (discussed in further detail below).

Medicaid's prescription drug expenditures are expected to decline in 2006 when the Medicare prescription drug benefit goes into effect. At that time, the cost of drug coverage for those Medicaid beneficiaries who are also eligible for Medicare will shift to the Medicare program.

Payment for Acquisition Costs

Prescription drug payments by Medicaid are based on formulas established by each state's Medicaid program. Most formulas start with AWP and then reduce it by a certain percentage, typically in the range of 5 to 16 percent for brand-name drugs. Many states vary their formulas, depending on whether the drug is generic or brand name, or single source (produced by one manufacturer) or multiple source (produced by more than one manufacturer). The formula may also vary for retail or mail-order pharmacies or for independent or chain drug stores. Formulas for generic drugs and multiple source drugs usually include a larger discount. (See Appendix 1 for a complete list of the state Medicaid reimbursement formulas for the quarter ending March 2005.)

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The discount below AWP in state reimbursement formulas is intended to account for the fact that the actual cost to pharmacies to acquire a drug may be well below this published benchmark. The difference between the pharmacy's cost of obtaining the drug and the reimbursement amount is retained by the pharmacy, creating an incentive for pharmacies to dispense drugs for which they have negotiated good prices.[10] Concern has been raised that, in some cases, this provides an incentive for manufacturers to raise a drug's AWP, particularly for a generic or multiple source drug, without changing the price at which they actually sell the drug in order to encourage pharmacies to purchase their product. Many states, in their continued efforts to control prescription drug spending, have changed their reimbursement formulas, increasing the discount from AWP at which they pay for prescription drugs.

Although states develop their own reimbursement formulas, the federal government contributes financially to state Medicaid programs and thus exerts some control over payment formulas by limiting the payment amounts it will match for specific drugs.[11] These "ceilings" differ for brand-name and generic drugs. The maximum amount that the federal government will match for brand-name drugs, or drugs with fewer than three generic versions, is the lesser of two figures: a drug's estimated acquisition cost (EAC),[12] which is a state's best estimate of the price generally paid by pharmacies for the drug (often based on AWP minus a certain percentage), or the pharmacy's usual and customary charge to the general public. The ceiling amount is usually the EAC.[13]

For drugs with at least three therapeutically equivalent generic versions, the federal ceiling is known as the federal upper limit (FUL), which is established and periodically revised by CMS. The FUL is intended to enable the federal government to realize savings from prices that are driven by competition in the market. The FUL is set at 150 percent of the price listed in any of the published compendia of drug cost information for the least costly therapeutically equivalent drug that can be purchased by pharmacies.[14] If a state's aggregate expenditures for drugs subject to an FUL exceed the amount the state would have otherwise spent by applying the individual drugs' limits (plus a reasonable dispensing fee), the state will not receive federal matching funds for any amount above that limit.[15]

Most states also have payment limits, known as maximum allowable cost limits (MACs), that may control the price they will pay. States may use their MACs instead of the FUL, provided they are not higher than the federal limit. States may also apply MACs to drugs not subject to the federal limit. Approximately 40 states have developed MAC programs.[16]

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Dispensing Fees

In addition to the cost of the drug itself, state Medicaid programs pay pharmacies a dispensing fee to cover the costs of filling each prescription. According to CMS regulations, the fee must be "reasonable," though this term is not defined. Each state sets its own dispensing fee, thus creating wide variation in these fees across the states. Typically, these fees are in the range of three to five dollars, with many states varying their dispensing fees based on whether the drug is brand-name or generic and the type of pharmacy dispensing it.

AWP as a Benchmark

Even though the use of ceilings and limits to contain the costs of prescription drugs, reliance on AWP as a pricing benchmark has proven problematic. A September 2002 report by the Office of the Inspector General (OIG) within the Department of Health and Human Services provided a breakdown of the acquisition costs that were paid by pharmacies for four

different categories of prescription drugs.[17] These acquisition costs, in most cases, were substantially below the payments being made by state Medicaid programs. The OIG analyzed acquisition prices for drugs in the following categories: (*a*) single source innovator drugs, (*b*) drugs without FULs, (*c*) multiple source drugs without FULs, and (*d*) multiple source drugs with FULs. The findings indicated that there were vast differences—ranging from 17.2 percent to 72.1 percent below AWP—in the discounts available to pharmacies for these categories of drugs. Based on these findings, the OIG recommended that CMS encourage states to adopt a four-tier reimbursement system based on the above categories, if the AWP benchmark continues to be used.[18]

The Congressional Budget Office (CBO) also examined state payments for prescription drugs and found that the average spread for these drugs—that is, the difference between the amount Medicaid paid and the amount paid by the pharmacy or wholesaler to the manufacturer—has risen significantly and varies by type of drug. The CBO found that between 1997 and 2002, the average spread increased 60 percent for drugs paid for by Medicaid programs, rising from $8.70 to $13.80 per prescription, at a rate of approximately 9.7 percent per year.[19] Driving these increases, according to the CBO, is the fact that Medicaid reimbursement formulas rely on AWP, a figure that is controlled by drug manufacturers who can use the high markup on a drug to compete for pharmacies' business, particularly for generic or multiple source drugs from which a pharmacy may choose among different available products.

The rate of growth in Medicaid drug markups did slow between 2000 and 2002, most likely due to states' efforts to change their reimbursement methodologies to reduce their payment rates.[20] In addition to revising their reimbursement formulas, many states have sought relief from high prescription drug spending by filing suit against drug manufacturers. In the past two years, approximately 20 states have sought to recover what they believe are overpayments for Medicaid drugs resulting from drug manufacturers reporting inflated AWPs.[21]

The Medicaid Drug Rebate Program

Established in the Omnibus Budget Reconciliation Act of 1990, the Medicaid Drug Rebate Program helps states control their prescription drug spending by requiring drug manufacturers to sign a rebate agreement with the federal government in return for coverage of their outpatient prescription drug products by state Medicaid programs. As stated previously, states received $9.2 billion in rebates from drug manufacturers in 2004.

Medicaid payments to pharmacies are calculated separately from rebates available through the Medicaid Drug Rebate Program; therefore, the net prices paid by Medicaid may not be the same as those available to private purchasers. Because the rebate formula for brand-name drugs is based

on the relation between AMP and best price, the rebate will be greater for those drugs for which the manufacturer is providing deeper private sector discounts. The Medicaid rebate amounts are established by federal statute and differ for brand-name and generic drugs.

- **Brand-name or single source drugs.** The rebate is the difference between the AMP (the average price paid to a manufacturer for drugs distributed through retail and mail-order pharmacies) and the manufacturer's best price (the lowest price paid to a manufacturer by any private sector purchaser within the United States). The minimum rebate is set at 15.1 percent of AMP.[22] An additional rebate must also be provided for any drug whose AMP has increased by more than inflation, as measured by the Consumer Price Index for All Urban Consumers (CPI-U).[23] This additional rebate is equal to the amount by which the current AMP for the drug exceeds the drug's AMP from July 1, 1990, adjusted for the percentage increase in the CPI-U since that time. This rebate is intended to protect the Medicaid program from prescription drug prices that are increasing more quickly than the rate of inflation.
- **Generic drugs.** The rebate equals 11 percent of the product's AMP.[24]

Concern has been raised about the accuracy of prices reported for purposes of calculating Medicaid rebates. A recent study by the GAO looked at the oversight provided by CMS of the prices reported by drug manufacturers, as well as the methods used by manufacturers to determine their submissions. Results of the study found inadequate oversight by CMS of the pricing data and variation in the methods used by drug manufacturers to determine best price and AMP. Some of these methods may have led to an underpayment or overpayment of rebates to states. GAO also found that AMP and best price may not take into account all the financial concessions offered to other purchasers in the private market. As a result of their findings, the GAO recommended increased guidance for, and oversight of, manufacturer price determinations.[25]

MEDICARE

Under Part B, the supplementary medical insurance component of Medicare, coverage includes a limited set of outpatient drugs that consists primarily of physician-administered drugs, such as chemotherapy, or drugs that are self-administered with durable medical equipment, such as inhalation therapy drugs.[26] In 2003, Medicare spent $10.34 billion on Part B drugs.[27]

The MMA addressed long-standing concerns that Medicare outpatient drug payments were too high and that the payment method created incentives for providers to administer drugs for which their acquisition costs were significantly lower than the Medicare reimbursement rate (95 percent of AWP).[28] Studies indicated that providers were able to acquire drugs

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at prices that were well below the Medicare payment rate, thus retaining the difference between the two prices. A GAO report found that, in 2000, Medicare paid approximately $1 billion above acquisition costs for Part B drugs. This spread provided physicians who purchased Part B drugs, many of whom are specialists in the areas of oncology and urology, with reimbursements that were significantly higher than their acquisition costs.

Providers argued, however, that this overpayment was needed to cover the cost of administering these Part B drugs. They claimed that physician fee schedule payments (for physician-administered chemotherapy, for example) and the pharmacists' monthly dispensing fee (for inhalation drugs) were too low.

In response to these concerns, as part of the MMA, lawmakers substituted the ASP for the AWP as the benchmark for the reimbursement of most Part B drugs.[29] Beginning January 1, 2005, payment for most Part B drugs and biologicals (for example, blood products and vaccines) shifted to 106 percent of the ASP.[30] Because the ASP is the weighted average of actual prices paid (and accounts for pricing adjustments such as discounts and rebates), it is thought to more closely represent the cost of acquisition. Therefore, the use of the ASP as the benchmark is expected to reduce the ability of manufacturers to market this spread. As part of these changes, drug manufacturers were required to begin submitting to CMS in 2004 the ASP for each of their Part B–covered drugs on a quarterly basis. Whether this ASP data will be more accurate than AWP depends on the manner in which it is reported by drug manufacturers and the timeliness of reporting. The MMA also boosted Medicare payments for administering Part B drugs.[31]

Initial analysis indicates that the ASP more accurately reflects actual acquisition costs. Two studies by the GAO assessed the adequacy of Medicare payments for chemotherapy-related drugs and their administration and for inhalation therapy drugs. They found that drug payments, if based on ASP, would be more closely aligned with acquisition costs in 2005 than they had been in 2003. Based on preliminary drug payment rates for 2005, GAO estimated that Medicare payment rates for 16 drugs billed by oncologists would exceed acquisition costs by an average of 6 percent.[32] In its evaluation of the costs of inhalation therapy drugs, GAO noted the wide variation in acquisition prices in 2003.[33] In its comments on the report, CMS said that preliminary ASP-based payments were within the range of acquisition prices reported by GAO.

Some oncologists have criticized the manner in which the MMA-updated drug payments have been calculated, noting that ASP will be closer to the prices offered to large purchasers, which may not represent the prices available to providers in private practice. They continue to express concern about the adequacy of Medicare payments for the services they provide and the potential impact on patients' access to chemotherapy services.

Under the new prescription drug benefit created by the MMA, payment will not be made directly by the government, as is currently done for

Medicare outpatient drugs. The new prescription drug benefit will be provided to enrollees through private plans that are participating in the Medicare program. It is expected that private plans, which typically rely on AWP as a starting point for negotiating with pharmacies, will do the same under the new drug benefit. Private plans will also negotiate with drug manufacturers for discounts and other price concessions. Discounts may be based on factors such as market share and plans' ability to influence providers' prescribing patterns, for example, through the use of formularies or lists of preferred drugs.

OTHER GOVERNMENT DRUG PURCHASING PROGRAMS

Federal and state government programs accounted for more than 20 percent of U.S. expenditures on outpatient prescription drugs in 2003.[34] In addition to Medicaid and Medicare, other federal government programs pay for prescription drugs at prices that vary from program to program.

340B "Covered Entities"

According to the GAO, drug manufacturers reduced the discounts they provided to private purchasers to keep the best price from triggering larger Medicaid rebates after implementation of the Medicaid Drug Rebate Program.[35] As a result, government spending on drugs for other federal- and state-supported providers increased. In response, Congress enacted Section 340B of the Public Health Service Act in November 1992, which requires drug manufacturers who participate in the Medicaid program to enter into an agreement with the Secretary of Health and Human Services. Under this agreement, the manufacturer provides discounts on drugs purchased by "covered entities" that serve vulnerable patient populations, including certain high-volume disproportionate share hospitals (hospitals that provide a disproportionate amount of care to low-income individuals). They also provide discounts to specified grantees of the Public Health Service, including certain federally qualified health centers, state-operated AIDS drug assistance programs, public housing primary care clinics, and homeless clinics.

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The 340B discount is calculated with the same formula used in the Medicaid Drug Rebate Program. Covered entities receive a minimum discount of 15.1 percent of AMP for brand-name drugs and 11 percent of AMP for generic and over-the-counter drugs, and they are entitled to an additional discount if the price of the drug increases faster than the rate of inflation. Covered entities are free to negotiate greater discounts to achieve prices that are even lower.

VA and Other Federal Purchasers

The VA uses several methods to reduce its prices for prescription drugs. First, prices paid to manufacturers by the VA, other federal agencies, and certain other entities, such as Indian tribal governments, that provide prescription drugs to their populations, are set by the FSS. The FSS is a list of pharmaceutical products and negotiated prices available to federal entities. It is derived from actual market transaction data reported by drug manufacturers to the VA. The FSS price is equal to or lower than the price given to any of the drug manufacturer's nonfederal purchasers. Under the Veterans Health Care Act of 1992, manufacturers must make drugs available to covered entities at the FSS price as a condition of eligibility for Medicaid reimbursement.[36] Manufacturers must sell brand-name drugs that are included in the FSS to the VA, Department of Defense, Public Health Service, and Coast Guard (known as the "Big Four") at the federal ceiling price (FCP), a price that is lower than the FSS price for many drugs.[37] In addition to being entitled to very low prices under federal law, the VA is able to affect prescribing patterns and influence market share because it delivers as well as pays for care. As a result, the VA routinely uses competitive bidding to obtain lower prices for drugs that have therapeutic equivalents. According to a study done by GAO between December 1999 and June 2000, this resulted in prices that were approximately one-third lower than FSS prices.[38]

CONCLUSION

Growth in prescription drug spending is a major concern for all payers, including Medicaid and other government programs. Private payers often pool their purchasing power through third parties to negotiate lower prices, rebates, or discounts to control their drug spending. Because negotiations may occur at various points in the supply or distribution chain, the actual net price to any payer for a given drug product may be very difficult to compute. Most of the negotiations are proprietary, further complicating efforts to determine the actual price paid.

Government programs have tried to use the privately negotiated prices as benchmarks for setting their own prices. The new Medicare outpatient prescription drug program will try a different tack by having private plans develop products for Medicare beneficiaries with premiums that are based on the covered drugs, their utilization, and the prices the private plans have negotiated. In this way, premiums, rather than prices, will be the comparison benchmark. Whether this approach is more successful in controlling spending growth has yet to be determined.

Government payers in particular will need to monitor whether any progress is made through current efforts to mitigate costs while still attempting to pay suppliers and providers a reasonable fee for their services. With record deficits at the federal and state level, spending on prescription drugs will continue to be a focus for cost-containment efforts.

ENDNOTES

1. Kaiser Family Foundation, "Prescription Drug Trends," fact sheet, updated October 2004; available at www.kff.org/rxdrugs/3057-03.cfm.

2. Douglas Holtz-Eakin, Congressional Budget Office (CBO), "The Rebate Medicaid Receives on Brand-Name Prescription Drugs," letter to the Honorable Charles E. Grassley, Committee on Finance, U.S. Senate, June 21, 2005; available at www.cbo.gov/ftpdocs/64xx/doc6493/06-21-MedicaidRebate.pdf.

3. Kaiser Family Foundation, "Prescription Drug Trends."

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6. CBO, *Prices for Brand-Name Drugs Under Selected Federal Programs*, June 2005, 1; available at www.cbo.gov/ftpdocs/64xx/doc6481/06-16-PrescriptDrug.pdf.

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13. Schneider and Elam, *Medicaid: Purchasing Prescription Drugs*, 15.

14. Schneider and Elam, *Medicaid: Purchasing Prescription Drugs*, 17.

15. Centers for Medicare & Medicaid Services, "Federal Upper Limit on Drugs"; available at www.cms.hhs.gov/medicaid/drugs/drug10.asp.

16. CBO, *Medicaid's Reimbursements*, 9–10.

17. Office of Inspector General (OIG), *Medicaid Pharmacy — Additional Analyses of the Actual Acquisition Cost of Prescription Drug Products,* A-06-02-00041, U.S. Department of Health and Human Services, September 16, 2002; available at http://oig.hhs.gov/oas/reports/region6/60200041.pdf. This report followed an earlier August 2001 OIG report (*Medicaid Pharmacy — Actual Acquisition Cost of Brand Name Prescription Drug Products,* A-06-00-00023, U.S. Department of Health and Human Services; available at http://oig.hhs.gov/oas/reports/region6/60000023.pdf) which found that the average acquisition cost paid by pharmacies for brand-name drugs was 21.8 percent below AWP. The later 2002 report came in the wake of criticism of the methodology and findings of the earlier report.

18. OIG, *Medicaid Pharmacy* (A-06-00-00023), 10.

19. CBO, *Medicaid's Reimbursements*, 1.

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20. CBO, *Medicaid's Reimbursements*, 11.

21. "Illinois Attorney General Sues 48 Pharmaceutical Companies Alleging Inflated Prices for Medicaid, Medicare," The Henry J. Kaiser Family Foundation, Daily Reports, February 8, 2005; available at www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=28040.

22. Bruen, "Medicaid and Prescription Drugs: An Overview," 4.

23. The Consumer Price Index for All Urban Consumers (CPI-U) is a measure of the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services.

24. Bruen, "Medicaid and Prescription Drugs: An Overview," 4.

25. GAO, *Medicaid Drug Rebate Program* (GAO-05-102), 23.

26. Medicare Part B covers approximately 450 drugs and biologicals. The following categories of outpatient drugs are covered under Medicare Part B: (*a*) drugs that are not self-administered and that are furnished "incident to" a physician's service, such as prostate cancer drugs; (*b*) certain self-administered oral cancer and antinausea drugs; (*c*) certain drugs used as part of durable medical equipment or infusion devices, such as inhalation drugs used with a nebulizer; (*d*) immunosuppressive drugs, which are used following organ transplants; (*e*) erythropoietin (EPO), which is the most costly drug for Medicare and is used primarily to treat anemia in patients with end-stage renal disease or cancer; (*f*) osteoporosis drugs furnished to certain beneficiaries by home health agencies; (*g*) vaccines for diseases such as influenza, pneumonia, and hepatitis.

27. Medicare Payment Advisory Commission, *Healthcare Spending and the Medicare Program*, data book, June 2005, 173.

28. Brand-name drugs were reimbursed at 95 percent of the AWP, and multisource drugs—drugs with generic equivalents or brand-name drugs with at least one competing product—were reimbursed at 95 percent of the lower of (*a*) the median AWP of all generic forms of the drug or (*b*) the lowest brand-name product's AWP. Beginning January 1, 2004, reimbursement for most Part B drugs was changed to 85 percent of AWP.

29. Certain Part B drugs and biologicals are exempt from these payment changes and will continue to be reimbursed at 95 percent of the AWP. These include blood and blood products; infusion drugs furnished through durable medical equipment; and influenza, pneumococcal, and hepatitis B vaccines.

30. Beginning July 1, 2006, physicians who administer Part B drugs will have the option of acquiring drugs through a voluntary competitive acquisition program (CAP). Rather than purchasing drugs in the market and seeking payment from Medicare, physicians will be able to obtain drugs from vendors participating in the CAP. The vendors would then be responsible for billing Medicare and collecting deductibles and coinsurance payments. Physicians not opting to participate in the CAP would continue to be reimbursed using the ASP methodology that is applicable for most Part B drugs.

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32. These selected drugs represented three-quarters of Medicare payments to oncologists in 2003. See GAO, "Medicare Chemotherapy Payments: New Drug and Administration Fees Are Closer to Providers' Costs," GAO-05-142R, December 1, 2004; available at www.gao.gov/new.items/d05142r.pdf.

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38. GAO, *Prescription Drugs: Expanding Access*, 11.

GLOSSARY OF DRUG PRICING TERMS

Average Manufacturer Price (AMP) — AMP is the average price paid to manufacturers by wholesalers (after discounts) for a particular dosage form and strength of a prescription drug distributed solely to the retail pharmacy class of trade. It excludes sales to institutional purchasers and others that would get low prices, but does reflect certain financial concessions, including discounts available to drug purchasers. The AMP is not a published price. It is calculated by the manufacturer and submitted to CMS quarterly for purposes of calculating the Medicaid rebate.

Average Sales Price (ASP) — The ASP, which was statutorily defined in the MMA, is the weighted average of a manufacturer's sales prices for a drug (or biological) for all purchasers, net of certain pricing adjustments, such as discounts and rebates. It excludes sales that are exempt from inclusion in the determination of best price and sales at prices that are deemed nominal by the Secretary. As set forth by the MMA, the ASP is reported quarterly by drug manufacturers to CMS for certain outpatient drugs, replacing the AWP as the basis of Medicare payments as of January 1, 2005. The federal government has the authority to audit these calculations submitted to CMS and, in cases where a misrepresentation is found, civil monetary penalties may apply.

Average Wholesale Price (AWP) — AWP is the average list price that a manufacturer suggests wholesalers charge pharmacies. This published price is purchased by government entities, private insurance companies, and other purchasers and often serves as the basis for prescription drug reimbursement. The AWP has often been equated with a "sticker price" or "list price."

Best Price — The best price is the lowest price available from the manufacturer to any purchaser, with some exceptions. The best price must reflect certain financial concessions, such as discounts, that are available to drug purchasers. Prices charged to certain governmental purchasers are not considered in the determination of the best price.

Estimated Acquisition Cost (EAC) — The EAC is a state's best estimate of the price generally paid by pharmacies. Most states use a drug's AWP to calculate the drug's EAC.

Federal Ceiling Price (FCP) — The FCP is the maximum price that manufacturers can charge the "Big Four" (the VA, DOD, PHS, and Coast Guard) for brand-name drugs.

Federal Supply Schedule (FSS) — The FSS price, which is negotiated by the Department of Veterans Affairs (VA), is the price available to direct federal purchasers of prescription drugs, including the VA, the Department of Defense, and the Public Health Service, among others. The FSS price

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is equal to or lower than the price given to any of the drug manufacturer's nonfederal purchasers. Manufacturers must make their brand-name drugs available at the FSS price in order to receive reimbursements for drugs covered by Medicaid. The FSS prices are publicly available.

Federal Upper Limit (FUL) — The FUL is the federal payment ceiling under Medicaid that applies to drugs with three or more generic versions. The FUL is set at 150 percent of the published price (in any of the published compendia of cost information for drugs) for the least costly therapeutic equivalent that can be purchased by pharmacists in quantities of 100 tablets or capsules.

Maximum Allowable Cost (MAC) — State MAC programs are prescription drug cost management programs that enable states to establish maximum reimbursement amounts that they will pay for selected generic and multiple source drugs. State MAC lists typically include more drugs than the FUL list and must have payment limits that are no higher than the federal list. Private third-party payers, such as PBMs, may also establish their own MACs.

Retail Price — The retail price, or usual and customary price, is charged by retail pharmacies to individuals without insurance, known as "cash-paying" customers.

Wholesale Acquisition Cost (WAC) — The WAC is the manufacturer's list price charged to wholesalers or direct purchasers, not including prompt pay or other discounts, rebates, or reductions in price, as reported in wholesale price guides or other drug pricing publications.

APPENDIX I
Medicaid Prescription Reimbursement Information by State – Quarter Ending March 2005

State	Ingredient Cost	Dispensing Fee	Co-pay	State MAC
Alabama	WAC + 9.2%, then AWP – 10%	$5.40	$0.50–$3.00*	Yes
Alaska	AWP – 5%	$3.45–$11.46 (based on pharmacy / Medicaid volume)	$2.00	No
Arizona	AWP – 15%	$2.00 (fee-for-service only)	None	No
Arkansas	AWP – 20% (generic) AWP – 14% (brand)	$5.51	$0.50–$3.00*	Yes
California	AWP – 17%	$7.25 $8.00 (legend: skilled nursing & intermediate care facilities)	$1.00	Yes
Colorado	AWP – 35% (generic) AWP – 13.5% (brand)	$4.00 (retail pharmacy) $1.89 (institutional pharmacy)	$0.75 (generic) $3.00 (brand)	Yes
Connecticut	AWP – 40% (generic) AWP – 12% (brand)	$3.60	$1.00	Yes
Delaware	AWP – 14% (traditional: retail independent & retail chain pharmacies) AWP – 16% (nontraditional: long-term care & speciality pharmacies)	$3.65	None	Yes
DC	AWP – 10%	$4.50	$1.00	No
Florida	Lower of AWP – 15.45% WAC + 5.75%; FUL or SMAC	$4.23 $4.73 (NH / long-term care)	2.5% of payment, up to $300	Yes
Georgia	AWP – 11%	$4.63 (brand for profit pharmacy) $4.33 (brand not for profit) $5.13 (generic for profit pharmacy) $4.63 (generic not for profit)	$0.50 (generic) $0.50–$3.00* (brand) $0.50 (preferred brand)	Yes
Hawaii	AWP – 10.5%	$4.67	None	Yes

AWP = average wholesale price; WAC = wholesale acquisition cost; NH = nursing home *Co-pay varies by cost of prescription.

State	Ingredient Cost	Dispensing Fee	Co-pay	State MAC
Idaho	AWP – 12%	$4.94 ($5.54 for unit dose)	None	Yes
Illinois	AWP – 25% (generic) AWP – 12% (brand)	$4.60 (generic) $3.40 (brand)	$0.00 (generic) $3.00 (brand)	Yes
Indiana	AWP – 20% (generic) AWP – 13.5% (brand)	$4.90	$3.00	Yes
Iowa	AWP – 12%	$4.26	$1.00	Yes
Kansas	AWP – 27% (generic) AWP – 13% (single source)	$3.40	$3.00	Yes
Kentucky	AWP – 12%	$4.51	$1.00	Yes
Louisiana	AWP – 13.5% (AWP – 15% for chains)	$5.77	$0.50–$3.00*	Yes
Maine	AWP – 15%; Direct supply drug list: usual & customary charge or AWP – 17% + $3.35 professional fee or FUL or MAC + $3.35 professional fee (Mail order: lowest of usual & customary charge, AWP – 20% + $1.00 professional fee. For exceptions, see State plan, FUL or MAC + $1.00 professional fee)	$3.35 $4.35 & $5.35 (compounding) $12.50 (insulin syringe)	$2.50 (generic & brand: not to exceed $25 per month; mail order: not subject to co-pay) $3.00 per day RHC (maximum of $30.00 per month, per individual)	Yes
Maryland	Lower of AWP – 12% or WAC+ 8%, direct price + 8% or distributor price when available	$3.69 (generic) $2.69 (brand) $4.69 (generic, NH) $3.69 (brand, NH) $7.25 (home IV therapy)	$1.00–$2.00	Yes
Massachusetts	WAC + 5%	$3.50 (single source) $5.00 (multiple source)	$1.00 (multiple source & nonlegend over-the-counter) $3.00 (nonexempt)	Yes
Michigan	AWP – 13.5% (indep. pharm.: 1–4 stores) AWP – 15.1% (chain: 5+ stores)	$2.50 $2.75 (long-term care)	$1.00 (generic) $3.00 (brand)	Yes

AWP = average wholesale price; WAC = wholesale acquisition cost; NH = nursing home *Co-pay varies by cost of prescription.

State	Ingredient Cost	Dispensing Fee	Co-pay	State MAC
Minnesota	AWP – 11.5%	$3.65 (+$0.50 for legend unit dose drugs)	$1.00 (generic) $3.00 (brand)	Yes
Mississippi	AWP – 12%	$3.91; allows for a reasonable dispensing fee for over-the-counter	$1.00 (generic) $2.00 (preferred brand) $3.00 (brand)	No
Missouri	Lower of AWP – 10.43% or WAC + 10%	$4.09	$0.50–$2.00*	Yes
Montana	AWP – 15%	$4.70	$1.00	No
Nebraska	AWP – 11%	$3.27–$5.00 (based on service delivery, unit dosage or 3rd party payors)	$2.00	Yes
Nevada	AWP – 15%	$4.76 $22.40 daily (home IV therapy) $16.80 daily (NF home IV therapy)	$1.00 (generic) $2.00 (brand)	No
New Hampshire	AWP – 16%	$1.75	$1.00 (generic) $2.00 (brand & compound)	Yes
New Jersey	AWP – 12.5%	$3.73 $4.07 (additional services)	None	No
New Mexico	AWP – 14%	$3.65	None	Yes
New York	AWP – 12%	$4.50 (generic) $3.50 (brand)	$0.50 (generic) $2.00 (brand)	No
North Carolina	AWP – 10%	$5.60 (generic) $4.00 (brand)	$1.00 (generic) $3.00 (brand)	Yes
North Dakota	AWP – 10%	$5.60 (generic) $4.60 (brand)	$3.00 (brand)	No
Ohio	Lower of WAC + 9% or AWP – 12.8%	$3.70	$3.00 (if not on PDL)	Yes
Oklahoma	AWP – 12%	$4.15	$1.00–$2.00*	Yes
Oregon	AWP – 11% (institutional) AWP – 15% (noninstitutional)	$3.50 (retail) $3.91 (institutional)	$2.00 (generic) $3.00 (brand)	Yes

AWP = average wholesale price; WAC = wholesale acquisition cost; NH = nursing home *Co-pay varies by cost of prescription.

State	Ingredient Cost	Dispensing Fee	Co-pay	State MAC
Pennsylvania	AWP – 10%	$4.00	$1.00	No
Rhode Island	WAC + 5%	$3.40 (outpatient) $2.85 (long-term care)	None	No
South Carolina	AWP – 10%	$4.05 (independent pharmacy) $3.15 (institutional)	$3.00	Yes
South Dakota	AWP – 10.5%	$4.75 ($5.55 for unit dose)	$2.00	Yes
Tennessee	AWP – 13%	$2.50 (long-term care dual eligibility) $5.00 (NH only, if more than 28 days)	N/A	Yes
Texas	Lower of AWP – 15% or WAC + 12%	$5.14	None	Yes
Utah	AWP – 15%	$3.90 (urban) $4.40 (rural)	$3.00	Yes
Vermont	AWP – 11.9%	$4.25	$1.00–$3.00*	Yes
Virginia	AWP – 10.25%	$3.75 $5.00 (unit dose drugs)	$1.00	Yes
Washington	AWP – 14% (single source & multiple source from 2–4 manufacturers) AWP – 50% (multiple source from 5 or more manufacturers) AWP – 19% (brand, mail order) AWP – 15% (generic, mail order)	$4.20–$5.20 (based on three-tiered pharmacy volume) $3.25 (mail order)	None	Yes
West Virginia	AWP – 12%	$3.90 (+$1.00 for compounding)	$0.50–$3.00*	No
Wisconsin	AWP – 11.25%	$4.88	$0.50 (over-the-counter) $3.00 (brand) $1.00 (generic)	Yes
Wyoming	AWP – 11%	$5.00	$2.00	Yes

AWP = average wholesale price; WAC = wholesale acquisition cost; NH = nursing home *Co-pay varies by cost of prescription.

Source: Adapted from CMS, "Medicaid Prescription Reimbursement Information by State," derived from CMS Approved State Plans, revised March 29, 2005; available at www.cms.hhs.gov/medicaid/drugs/prescriptions.asp.