

How Pharmacy Reimbursement Methods Have Evolved

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Drug reimbursement from commercial insurance carriers changed considerably over the last decade. The old standard used to be Average Wholesale Price (AWP), which reflected the average prices of drugs sold to hospitals, physicians and pharmacies. Insurance companies often reimbursed drugs using AWP, or more likely a percentage above or below AWP, as agreed to by a carrier and provider. From the perspective of an insurance company, payment based on AWP was a positive event, reducing reimbursement, as prior to

AWP medications were often paid on a percent-of-charge basis.

Earlier this decade, however, interested parties began to notice problems with AWP as a standard for drug reimbursement. AWP was criticized as arbitrary, as it was not based on actual drug costs but on the prices charged by wholesalers and manufacturers for drugs. Manufacturers of course built a profit margin into their charges for medications, so the AWP standard could be established at an artificially high level. AWP was additionally self-reported by the drug manufacturers and did not take into account the discounts and rebates often agreed to in negotiations of drug reimbursement. By 2003 or so AWP was widely considered to be inaccurate at best, and a meaningless payment standard at worst.

As often happens in medical reimbursement (think DRGs and APCs), the federal government stepped forward to address the situation. In 2005, Congress changed the way Medicare handled drug reimbursement. AWP was replaced by Average Sales Price (ASP).

ASP was seen as a more accurate reflection of the actual cost of drugs, as it took into account the actual sales transaction information AWP did not, such as rebates

and discounts.

A 2005 OIG study comparing over 2000 drugs determined that ASP was approximately 26% lower than AWP for branded drugs and 68% percent lower than AWP for generics. The commercial insurance carriers moved as swiftly as they could to negotiate new agreements that drove reimbursement for medications to the new ASP standard during the period from 2005 to 2010. These agreements were typically based on a percentage of ASP, or a percentage of the Medicare payment rate of ASP + 6%. The result was often a reduction in drug reimbursement to providers, in some cases dramatically so.

The evolution of drug reimbursement is not as simple as AWP being replaced by ASP, with the carriers now paying providers less for drugs. In the last few years another standard has been established for drug reimbursement, Wholesale Acquisition Cost, or WAC.

WAC's are arguably even more precise than ASP. While ASP takes into account the transactional information AWP does not, WAC's are the actual costs wholesalers pay when they buy drugs from manufacturers. They are reported also directly by the distributors them-

selves, as opposed to ASP, which is typically reported by companies such as McKesson.

Some observers have pointed out that a weakness exists with WAC since like AWP, it fails to reflect rebates and discounts the way ASP does. WAC proponents have countered that one cannot get more precise than listing the actual costs of drugs, making rebate data in some respects unnecessary. The debate continues and ASP continues to be the standard, but note that in our market at least one carrier is adapting the WAC methodology for certain medications.

To complicate matters even fur-

ther, the federal government began using another standard, Average Manufacturer Price (AMP), for the federal component of the Medicaid program. AMP excludes any prompt payment discounts, and drug manufacturers must report AMP information to CMS. The OIG issued a report stating that AMP is lower than AWP and WAC. Yet even here there is controversy as observers have noted that there is not much difference between AMP and ASP. A lawsuit was filed in 2007 which ultimately prevented CMS from publishing and using AMP for reimbursement. Currently AMP is used by the government

on an internal Medicaid basis only.

What should you do about this complex issue? Generally, try to keep your drug reimbursement tied to AWP if at all possible. If you have to be on one of the other methodologies, consider seeking assistance from qualified negotiators or try other strategies such as negotiating as high a percentage above the base as you can. Good luck!

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