

## Make Treatments more Affordable

### Congress Must Address the Risks Facing Vulnerable Patients and Clinical Care Teams

**Under Medicare Part B, many treatments are administered in a doctor's office or clinic.** The physician practice buys the drug upfront from the manufacturer or distributor, properly stores, and then administers the drug to the patient. Medicare reimburses the practice later based on the Average Sales Price [adjusted slightly for sequestration] + 6% [usually]. As a result, doctors are fronting the cost of these drugs, which often cost thousands or tens of thousands of dollars per dose, when reimbursement may not cover the cost or be timely.

**Physicians and their practices take on major financial risk** as they must pay for expensive drugs upon acquisition before getting reimbursed after administering the treatment.

- Where reimbursement is delayed, reduced, or doesn't fully cover costs they lose money on every dose.
- Even when reimbursement is theoretically adequate, cashflow may disrupt care. Claims denials, coding errors, and slow payments can leave practices in limbo for weeks or months.
- Smaller practices, rural clinics, and safety net clinics are especially vulnerable as they cannot absorb financial risk like large hospital systems.

**Unfortunately, some physician practices must stop offering certain therapies** because they can't afford to carry them. This leads to fewer local treatment options and patients traveling farther, waiting longer, or forgoing care altogether. When clinics limit which drugs they offer and refer patients elsewhere that treatment location is often farther away which can delay care or sometimes cause the patient to forgo care altogether. Typically, these shifts care to hospital outpatient departments, which are more expensive as they come with additional fees.

**A solution to this issue now is necessary** as in 2028, CMS will implement negotiated "Maximum Fair Prices" for Medicare Part B [physician-administered] drugs for the first time. This will impact how much physicians are paid after they administer treatment but will not reduce the acquisition costs for most clinics. Physicians have neither the ability to renegotiate drug acquisition prices quickly nor the leverage of larger buyers to reduce to purchase price.

PRACTICE BUYS THE DRUG FROM MANUFACTURER AT MANUFACTURER'S PRICE



MANUFACTURERS REPORT ASP TO CMS (INCLUDING BULK RATES NEGOTIATED BY HEALTHCARE SYSTEMS)



PRACTICE BILLS MEDICARE FOR REIMBURSEMENT OF DRUG



CMS REIMBURSES PRACTICE 106% OF ASP (MINUS SEQUESTER)



## The Protecting Patient Access to Cancer and Complex Therapies Act (H.R. 4299) is a bipartisan bill to address these concerns by ensuring:

- Savings without harm. Instead of cutting reimbursements per changes to the ASP, the bill requires manufacturers to provide drug rebates directly to Medicare. The patient and care team are out of the middle.
- Protection for personalized treatment. The most impactful therapy can be prescribed first, in the most appropriate setting, at the optimal time.
- Lower costs. Coinsurance is based on the lower Medicare Fair Price (MFP), so patients pay less for treatments.

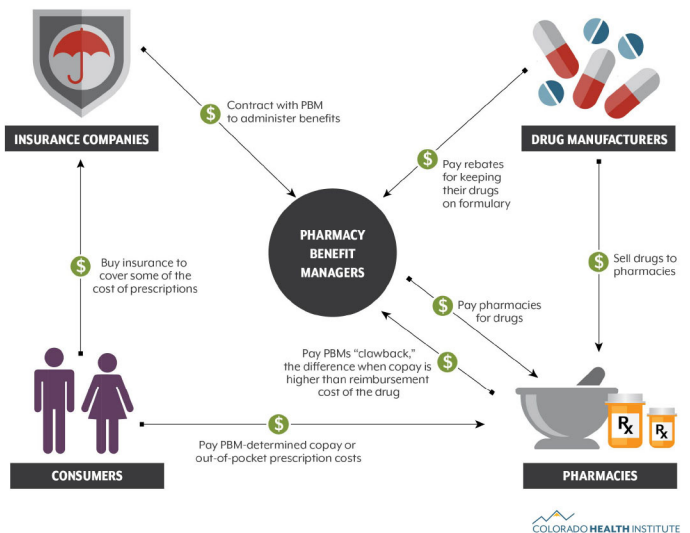
## Expand Pharmacy Benefit Manager Reform to Lower Costs

**Pharmacy benefit managers (PBMs) are major contributors to ballooning prescription drug prices**, the most substantial cost to patients and our healthcare system. PBMs manage prescription drug formularies on behalf of public and private payers. While originally created to negotiate savings for patients and plan sponsors, PBMs evolved into intermediaries pocketing hundreds of billions of dollars from our healthcare system while manufacturing nothing, providing no patient benefit and creating no savings by:

- Acting as intermediaries between insurers, drugmakers, and pharmacies.
- Setting patient copayment amounts and determining which drugs are covered by which insurers.
- Negotiating discounts and rebates from drugmakers in exchange for preferred placement of drugs on insurers' formularies.

**Three PBM companies collectively hold 80% of the market share.** Of those, CVS Caremark holds 34%, Express Scripts holds 25%, and Optum RX holds 21%. The latter two companies are owned by insurers. There are 60+ smaller PBMs looking to capitalize on the growing pie as the global PBM market is projected to increase from \$495 billion in 2022 to \$740 billion by 2029.

Figure 1. The Role of Pharmacy Benefit Managers



**Recently these business practices were mitigated by Congress** in Medicare and Medicaid, but PBMs play a central role in managing prescription drug benefits for group health plans. Their services typically include negotiating rebates with drug manufacturers, designing plan formularies, establishing pharmacy networks, and processing prescription drug claims. Under current law, PBMs are not legally obligated to act in the best interests of plan sponsors or patient participants.

## How Congress Can Help:

- Support **PBM Fiduciary Accountability, Integrity, and Reform (FAIR) Act** (S. 3549) to amend the Employee Retirement Income Security Act of 1974 (ERISA) to treat PBMs as fiduciaries, requiring them to place the interests of the health plan and its participants ahead of the PBM's financial interests. In addition, the legislation would:
  - Require PBMs to provide plan administrators detailed information regarding the direct and indirect compensation including rebates, administrative fees, and other forms of payment tied to prescription drug pricing.
  - Restrict PBMs' ability to shift responsibility for fiduciary breaches back to plans through contractual indemnification provisions.
- Support the **PBM Transparency Act** (S. 526) to ban spread pricing and require PBMs to report spread pricing and pharmacy fee profits to the Federal Trade Commission (FTC). "Spread pricing" is when PBMs charge health plans (employers/insurers) more for prescription drugs than they pay the pharmacy, pocketing the difference [the "spread"] as profit.
- Support **The DRUG Act** (H.R. 2214) to replace PBM fees based on the prices they negotiate for drugs with flat service fees and require 100% pass-through of negotiated rebates and discounts to health plans to lower premium costs for ERISA plans.