CSRO

Coalition of State Rheumatology Organizations

Medicare Patient Access & Practice Stabilization Act of 2024 (H.R.10073)

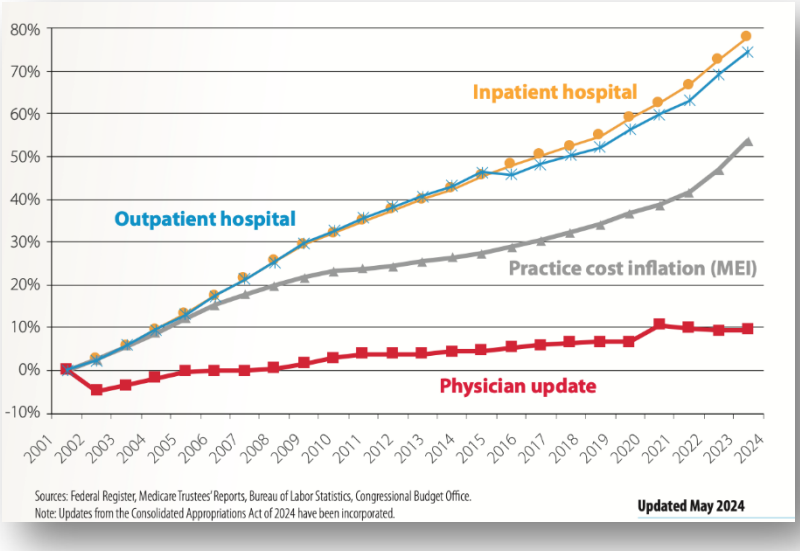
Eliminate the impending 2.8% Medicare Physician Fee Schedule cut and secure long term payment stability for physicians

Congressional Request

Cosponsor and advance the *Medicare Patient Access and Practice Stabilization Act of 2024* (H.R.10073) to stop the impending 2.8% Medicare Physician Fee Schedule cut for physicians from going into effect on January 1, 2025, and provide an inflationary update. Work to establish a long term, stable payment mechanism that appropriately pays physicians for health outcomes going forward.

Background

Unlike other healthcare providers, the Medicare Physician Fee Schedule (MPFS) does not receive annual payment updates based on an inflationary index, such as the Consumer Price Index (CPI). This has created an ever-growing disconnect between the cost of providing care to Medicare beneficiaries and the program's reimbursement for that care. According to the American Medical Association, when adjusted for medical practice cost inflation, Medicare physician payments have declined by 29% since 2001.[i] To make matters worse, physicians also face cuts from budget neutrality and Medicare sequestration – causing almost double-digit reductions for many physicians.



The Medicare Trustees[ii] and MedPAC[iii] have expressed concerns over the lack of an inflationary index applied to the MPFS, including potential healthcare consolidation if physicians are forced to sell their practices to larger health systems and private equity groups. Such consolidation would only increase costs within the healthcare system, as hospital payments are 23-41% higher than physician practice payments in Medicare Fee-for-Service.[iv]

On January 1, 2025, CMS will reduce Medicare reimbursement for physician services by 2.8%. If this cut goes into effect, physicians will face a total 6.4% cut due to the additional CMS estimated increase in practice expenses for 2025 at 3.6%.

The Solution

CSRO urges Congress to act before the end of the year to advance legislation that eliminates the impending 2.8% Medicare Physician Fee Schedule cut before it goes into effect on January 1, 2025, and provide an inflationary update.

Long term, CSRO urges Congress to enact solutions that stabilize Medicare physician payments by:

- stopping recurring Medicare cuts;
- providing an annual inflation update equal to the Medicare Economic Index (MEI); and
- updating the budget neutrality threshold to allow for greater flexibility in determining physician pricing adjustments for services without leading to harmful payment cuts.

CSRO supports the following policies from the 118th Congress that address a long term solution, including:

- Physician Fee Stabilization Act (S.4935)
- Strengthening Medicare for Patients and Providers Act (H.R.2474)
- Provider Reimbursement Stability Act (H.R.6371)
- Physician Fee Schedule Update and Improvements Act (H.R. 6545)

Contacts

To cosponsor ***Medicare Patient Access and Practice Stabilization Act of 2024*** (H.R.10073), please contact McLean.Piner@mail.house.gov (Rep. Muphy) or Seamus.Mckeon@mail.house.gov (Rep. Panetta)

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[i] American Medical Association. "Medicare physician pay has plummeted since 2001. Find out why." June 2024.
[ii] The Boards of Trustees, Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds. "2020 Annual Report." April 2020.
[iii] MedPAC. "Congressional request on health care provider consolidation." March 2020
[iv] Congressional Budget Office. "The Prices that Commercial Health Insurers and Medicare Pay for Hospitals and Physicians' Services." January 2022.

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COALITION OF STATE RHEUMATOLOGY ORGANIZATIONS

Pharmacy Benefit Manager (PBM) Reform

Prevent PBMs from abusive practices that harm patients and increase the cost of healthcare

Congressional Request

Within any end-of-year package, advance PBM reforms that incorporate delinking PBM reimbursement from the price of drugs and passing manufacturer rebates directly onto patients.

Background

Rheumatology patients were among the first to experience the harmful repercussions of PBM business practices because these conditions regularly require expensive specialty medications. These business practices were built on a system of perverse incentives, where the higher a drug's list price, the greater the income potential for the PBM. As a result, prescription drug formularies are designed to maximize PBM revenues, which explains how a $10,000 brand drug can gain formulary access while its $450 generic is not covered. In 2024, over 98% of Medicare Part D prescription drug plans covered brand-name Humira, while less than 54% cover just one biosimilar adalimumab product.[i] These formulary design decisions are disastrous for patients who pay coinsurances based on list prices.

The three largest PBMs —Caremark Rx, Express Scripts (ESI), and OptumRx— control 80% of the prescriptions filled in the United States, according to the Federal Trade Commission.[ii] This vertical integration allows the PBM to control what medication patients can take (through formulary construction), when they can take these medications (through utilization management), where they can purchase their medications (through pharmacy networks), and how much they must pay for their drugs (through cost-sharing). Currently, all of these decision points (what, when, where, and how) are leveraged to maximize PBM profits rather than providing the patient with the best care at the greatest savings. This consolidated healthcare system is not good for patients, and it ultimately decreases competition and increases costs for the federal government.

Delink PBM Compensation from Drug Prices

Several policies break the connection between the PBM's compensation and the list price of the drug, often referred to as "delinking." This would disincentivize PBMs from preferring higher priced medications because they would no longer benefit from the size of the rebate. Instead, PBMs would be reimbursed on a flat compensation fee. This approach would improve program stewardship and beneficiary access to affordable, clinically driven coverage. In the employer market, innovative PBMs are successfully using this model and provide fully transparent compensation models that offer savings to employers and patients

CSRO thanks Congress for including delinking provisions within the following legislation advanced by congressional committees:

- Modernizing and Ensuring PBM Accountability Act (S.2973, Section 2), as reported out of Senate Finance
- Accelerating Kids' Access to Care Act (H.R.4758, Section 3), as passed by the House
- Protecting Patients Against PBM Abuses Act (H.R.2880, Section 2), as marked up in House Energy & Commerce, Health Subcommittee
- Delinking Revenue from Unfair Gouging (DRUG) Act (S.1542/H.R.6283), as reported out of House Oversight and Accountability Committee

Pass Manufacturer Rebates Directly onto Patients

PBMs may negotiate aggressive rebates and discounts, but patients see little to no benefit from those "savings." In reality, list prices seem to be fictional for everyone *except* the patient, whose cost-sharing is often based on the full price. It's time for rebates and discounts to benefit the patient – not the PBMs, especially as many patients are enrolled in health insurance plans that utilize high deductibles or significant cost sharing.

Several policies require manufacturer rebates to bypass the PBM, but only some require the rebates to go directly to the patient. Given the immense vertical integration of PBMs and health insurance companies, policies that allow rebates to go directly to the health plan may have little impact in reducing patient expenses. Instead, rebates that go directly to the patient allow patients to see *immediate* savings at the point of sale. By reducing the patient's out-of-pocket cost, patients can continue to take their prescribed medications and improve adherence and health outcomes.

CSRO supports rebate pass through provisions included within the following legislation:

- Better Mental Health Care, Lower-Cost Drugs, and Extenders Act (S.3430, Section 203), as reported out of Senate Finance
- Share the Savings with Seniors Act (S.2474/H.R.5376)

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[i] Journal of the American Medical Association. "Formulary Coverage of Brand-Name Adalimumab and Biosimilars Across Medicare Part D Plans." June 2024.

[ii] Federal Trade Commission. "FTC Sues Prescription Drug Middlemen for Artificially Inflating Insulin Drug Prices." September 2024.

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"Underwater" Biosimilars

Remove barriers that hinder access to biosimilars by ensuring adequate physician reimbursement

Congressional Request

Work with the Centers for Medicare and Medicaid Services to meaningfully address underwater reimbursement for physician administered biosimilar medications.

Background

Reference biologics (i.e. brand biologics) and biosimilars are vitally important therapeutic options for patients with certain chronic diseases, including those treated by rheumatologists such as rheumatoid and psoriatic arthritis. Biosimilars can provide a lower cost alternative to the reference biologic and help with specialty medicines affordability. However, biosimilar uptake has been considerably slower than expected. While there may be several factors contributing to slow adoption, one key factor – underwater biosimilars – is causing significant barriers for several provider administered biosimilars.

Health insurance companies and their pharmacy benefit managers (PBMs) have exerted disproportionate pressure on pharmaceutical manufacturers to offer significant rebates in exchange for "fail first" status on their formularies. In many cases, certain highly rebated biosimilars have gained the "fail first" position, requiring patients to step through these medications before they can access others. These rebates are factored into the quarterly average sales price (ASP) for physician administered medications reported to the Centers for Medicare and Medicaid Services (CMS) and are artificially lowering the ASP for some physician administered biosimilars.

While insurance companies and PBMs benefit from price concessions, physicians who administer these biosimilar medications are reimbursed far less for the drug than it cost them to purchase it. This leads to a significant financial loss each time a provider administers one of these biosimilars, putting them financially "underwater" for the clinical visit. While Congress has increased the ASP "add-on" for select biosimilars for a limited five-year period through the *Inflation Reduction Act*, physicians are still underwater with these highly rebated biosimilars because the ASP is so artificially low. This disparity creates immediate financial hardship on physician practices and leads to an unsustainable situation.

When physicians cannot afford to offer these biosimilars due to underwater reimbursement, it leads to decreased overall biosimilar usage. It can also force providers to send patients elsewhere for treatment, often at a much higher cost. Independent, private practice in-office infusion centers are a much lower-cost option than hospitals infusion centers, where higher costs are incurred due to facility fees and elevated rates. If no alternative site can be secured, the patient ultimately loses access to the biosimilar medication because their insurance refuses to cover the reference product or any of the other biosimilar options. In only covering the "fail first" option, healthcare providers are left with no other choice but to try the patient on a completely different medication.

Ultimately, these perverse market incentives are forcing patients to "fail first" provider administered biosimilars that are unaffordable for the provider and lead to higher costs for the patient and the healthcare system, including the government and self-insured employers.

The Solution

As CMS does not have the necessary authority to meaningfully improve reimbursement for these drugs, we urge Congress to consider opportunities to address the ASP for underwater biosimilars:

1) Amend Section 1847A(b) of the Social Security Act (SSA) to temporarily provide an 8% add-on to the providers' acquisition cost of all biosimilar products;
2) Amend Section 1847A(c)(4) to extend the Secretary's authority to use wholesale acquisition cost (WAC) + 3% until ASP reaches sustainable levels, as determined by the Secretary; or
3) Amend Section 1847A(c)(3) to permanently remove manufacturer rebates from the ASP methodology for biosimilars.