CSRO
Coalition of State Rheumatology Organizations

BOARD OF DIRECTORS

Aaron Broadwell, MD
President

Gary Feldman, MD
Immediate Past President

Madelaine Feldman, MD
VP, Advocacy & Government Affairs

Michael Saitta, MD, MBA
Treasurer

Firas Kassab, MD
Secretary

Erin Arnold, MD
Director

Leyka Barbosa, MD
Director

Kostas Botsoglou, MD
Director

Mark Box, MD
Director

Michael Brooks, MD
Director

Amish Dave, MD, MPH
Director

Harry Gewanter, MD, MACR
Director

Adrienne Hollander, MD
Director

Robert Levin, MD
Director

Amar Majjhoo, MD
Director

Gregory Niemer, MD
Director

Joshua Stolow, MD
Director

EXECUTIVE OFFICE

Leslie Del Ponte
Executive Director

555 E. Wells Street, Suite 1100
Milwaukee, WI 53202-3823
Phone: 414.918.9825
Email: info@csro.info
Website: www.csro.info

May 26, 2026

Illinois State Senate
750 Stratton Building
Springfield, IL 62706

Concerns re: SB 3496 (HFA1) – State Application of Medicare Maximum Fair Price

Senate President Harmon and members of the Illinois Senate:

On behalf of the Chicago Rheumatism Society (CRS), the Coalition of State Rheumatology Organizations (CSRO) and the Association of Women in Rheumatology (AWIR), we would like to express concerns regarding SB 3496 (HFA1), which would create a Health Care Availability and Access Board that is empowered to apply the Medicare Maximum Fair Price to medications in Illinois. CRS, CSRO and AWIR serve the practicing rheumatologist with a mission to advocate for excellence in the field of rheumatology, ensuring access to the highest quality of care for the management of rheumatologic and musculoskeletal disease.

Rheumatologic diseases, such as rheumatoid arthritis, psoriatic arthritis and lupus, are systemic and incurable, but innovations in medicine over the last several decades have enabled rheumatologists to better manage these conditions. With access to the right treatment early in the disease, patients can generally delay or even avoid damage to their bones and joints, as well as reduce reliance on pain medications and other ancillary services, thus improving their quality of life.

Rheumatologists and other healthcare practices directly administer biologic products to patients at their in-office infusion suites. These practices engage in the "buy-and-bill" model, whereby the medical practice pre-purchases medications and submits a claim to the health plan for reimbursement once the medication is administered to a patient. This model allows patients to conveniently receive their essential medications at their doctor's office instead of the hospital, reducing their exposure to hospital-based infections—a particularly important consideration for immunocompromised individuals who receive provider-administered drugs. This model is also far more cost effective, with hospital outpatient departments charging an average of 129-211% more for drug administration reimbursement than freestanding physician offices.[i]

Impact of MFP on the ASP and Physician Administered Medications
While this legislation has taken efforts to exempt provider administration fees from the upper payment limit (UPL), we still fear this proposal may actually limit patient access and drive up the cost of medications instead of making them more affordable for patients. As currently drafted, the UPL caps a prescription drug list price at the Medicare Maximum Fair Price (MFP) selected by the Centers for Medicare & Medicaid Services (CMS) through the Medicare Drug Price Negotiation Program.

These provider administration fees are typically referred to as the add-on payment at a bundled rate for administered drugs, which is typically based on the average sales price (ASP) plus six percent. The ASP is a market-based price that considers the weighted average of all manufacturer sales prices for the drug, including rebates and discounts. The additional six percent add-on helps these medical practices account for acquisition costs, such as intake and storage, equipment and preparation, staff, facilities, and spoilage insurance. While ASP is a reference for Medicare, it is typically the basis for commercial reimbursement as well.

We strongly advise Illinois against using the Maximum Fair Price (MFP), as CMS intends to blend the MFP within the ASP calculation for provider administered medications. CMS inclusion of the MFP will deflate the overall ASP significantly, which then in turn will reduce the ASP base price percentage for provider administered add-on payments. In fact, according to a recent study by Avalere Health and commissioned by the Community Oncology Alliance, incorporating the MFP into the ASP calculation could reduce the ASP so precipitously that the calculated add-on payment for Part B reimbursements in Medicare would be 42-61% lower than the current reimbursement rates. This could also cause ripple effects into the commercial market, driving a 12-18% projected cut to physician reimbursements through the add-on payment.[ii] Rheumatologists and their practice partners already face significant financial strain if CMS does not rectify this issue, which CSRO has repeatedly requested they address. These providers cannot afford for Illinois to impose the same reduction in their administration fees.

Reimbursement rates that do not sufficiently compensate for acquisition costs put healthcare practices at risk. While we understand that theoretically a decreased base price would bring down the total cost per administered medication, such a precipitous drop in calculating provider reimbursement would lead to inadequate, or "underwater," reimbursement, forcing providers into an untenable position. As we mentioned, these buy-and-bill margins are already incredibly thin, so reduced reimbursement for these medications would be unsustainable for private physician practices. Indeed, some practices are already underwater on certain biosimilar medications, forcing providers to choose between administering the drug at an unsustainable financial loss or transferring the patient to another site of service that may be able to absorb the ASP loss, such as the hospital. Driving patients into the hospital for this care will drive up the cost of these services, which is counterproductive to the overall drug affordability goals of Illinois. Ultimately, the patient may lose access to the prescribed medication altogether, which could result in higher healthcare costs as a consequence of loss of control of their disease or the higher costs of an alternative treatment.

PBM Formulary Manipulation

While the legislation has placed a strong emphasis on prices and costs associated with the initial steps in the pharmaceutical supply chain, it is important to note that many pharmacy benefit plans utilize a variety of tactics that undermine the effectiveness of programs created to keep patient costs down, such as copay assistance programs. These pharmacy benefit plans, organized by pharmacy benefit managers (PBMs), contribute significantly to patient out-of-pocket costs, driving unaffordability.

We encourage the legislature to consider the role PBMs play in driving up the cost of prescription medications. If the Board pursues a UPL without any guardrails in place for PBMs, it is likely that these middlemen will manipulate the formularies so that these newly priced drugs are placed on a much higher tier, and therefore less accessible to patients. PBM business practices favor higher priced drugs because they have the potential to profit more off those medications. We strongly encourage the legislature to consider mechanisms that will ensure that drug placement on the formulary remains consistent if a UPL is implemented.

Actual Out-of-Pocket Costs
CRS, CSRO and AWIR believe it is important for the legislation to require the Board to consider typical out-of-pocket expenses for patients when considering whether the drug should be assigned a UPL. Copay assistance programs are designed to defray cost-sharing amounts charged to the patient by the health plan for their prescription drug. These programs cover most or all of the patient's cost-sharing responsibility through a direct payment at the point of sale to improve patient affordability.

We recognize that high priced drugs that do not offer copay assistance are a real financial threat to patient access, which has become more prevalent among some generic medications. However, when copay assistance programs are offered, the patient typically pays between $0 to $25 at the pharmacy counter for their medication. Copay assistance programs also help defray costs associated with administration for the provider administered formulation, making the copay assistance program particularly generous. While a drug's cost in a vacuum may induce sticker shock, these costs are almost never what a patient actually pays for their medication. We encourage the legislature to consider actual patient out-of-pocket costs as they review this legislation.

On behalf of practicing rheumatologists throughout Illinois, we request that you **do not advance SB 3496 (HFA1)**. We thank you for your consideration and are happy to further detail our comments upon request.

Respectfully,

Erin Arnold, MD, FACR
Advocacy Co-Chair
Chicago Rheumatism Society
Skokie, Illinois

Madelaine A. Feldman, MD, FACR
VP, Advocacy & Government Affairs
Coalition of State Rheumatology Organization

Angela Crowley, MD
Chicago Local Chapter Leader
Association of Women in Rheumatology
Willowbrook, Illinois

---

[i] Actuarial Research Corporation. "Potential Impacts of Medicare Site Neutrality on Off-Campus Drug Administration Costs." October 2023.
[ii] Avalere Health. "Commercial Spillover Impact of Part B Negotiations on Physicians." September 2024.