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Coalition of State Rheumatology Organizations

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Assembly Commerce and Labor Committee
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Carson City, NV 89701
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Concerns re: AB 259 – State Application of Medicare Maximum Fair Price

Chair Marzola, Vice Chair Jauregui and members of the Assembly Commerce and Labor Committee:

The Coalition of State Rheumatology Organizations (CSRO) would like to express concerns regarding AB 259, which would apply the Medicare maximum fair price to physician reimbursements for provider administered medications. CSRO serves the practicing rheumatologist and is comprised of over 40 state rheumatology societies nationwide with a mission of advocating for excellence in the field of rheumatology and 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.

This legislation would apply the Medicare maximum fair price to medications administered to patients throughout Nevada, thus capping physician reimbursement for selected provider administered medications. We fear this proposal may actually limit patient access to these medications, as the out- of -state acquisition cost for the provider may be much higher than the in-state reimbursement for these medications. This would cause a significant financial strain on physician practices throughout Nevada, and physicians would no longer be able to provide these drugs to their patients. Instead, patients would need to go to a more costly site of care, such as a hospital setting, or lose access to the medication altogether.

Physician Administered Medications

As currently drafted, the Medicare maximum fair price (MFP) caps provider reimbursement for a prescription drug selected by the Centers for Medicare & Medicaid services through the Medicare Drug Negotiation Program. While the legislation clearly exempts physician dispensing fees from the MFP, it does not address physician add-on fees for provider administered medications. It also fails to require that providers acquire the medication at a rate sufficiently below the MFP to account for acquisition costs to the provider. This is highly problematic for healthcare providers who administer medications directly to patients in outpatient settings, including rheumatologists across the state.

Rheumatologists and other healthcare practices that directly administer medications on an outpatient basis are typically engaged in "buy and bill," whereby the medical practice pre-purchases drugs and bills the health plan for reimbursement once the medication is administered to a patient. Margins for practices engaged in buy and bill are thin. To maintain the viability of administering drugs in outpatient settings – which are often more cost-effective settings for the payer and safer for immunocompromised patients – reimbursement must account for acquisition costs, such as intake and storage, equipment and preparation, staff, facilities, and spoilage insurance.

Currently, most health plans reimburse providers for the cost of the medication plus an add-on payment at a bundled rate to cover the acquisition costs, making office-based administration economically viable. Unfortunately, the MFP outlined in the legislation would prevent healthcare providers from collecting this add-on payment, making it untenable for healthcare providers in outpatient settings to administer medications that are subject to the MFP. Reimbursement rates that do not sufficiently compensate for these costs put healthcare practices at risk. If patients are unable to receive their medications in outpatient settings, they will be forced to receive provider administered care in hospital settings, which are more expensive to the payer.

Acquiring Medications Below the MFP

CSRO is also concerned that providers will be unable to source drug products below the MFP. Contracting between providers, their group purchasing organizations, wholesalers, and manufacturers is not geographically isolated and is often national in scope. The purchase of a drug product by a wholesaler from a manufacturer likely occurs out of state and would be outside of Nevada's ability to regulate. As a result, it is very likely that the price offered by the wholesaler to the medical practice would be significantly higher than the MFP that a physician could bill for that medication. This will impede providers from acquiring these products, resulting in medication access shortages and limited patient access to these essential medications.

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 manufacturer copay assistance cards. These policies, such as accumulator programs and maximizers, 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 legislature chooses to apply the MFP 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, or dropped from the formular altogether, 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 the MFP drugs are placed with parity to the non-MFP drugs on the formulary if MFP is applied to state administered medications.

Actual Out-of-Pocket Costs

CSRO believes it is important for the legislature to consider typical out-of-pocket expenses for patients when considering whether to advance this legislation. Copay assistance programs, such as manufacturer copay cards, 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 Nevada, we request that you do not advance AB 259 as many of the unintended consequences mentioned would reduce patient access to these drugs and cost the patient and the system more in the long run. We thank you for your consideration and are happy to further detail our comments to the Committee upon request.

Respectfully,

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