NATIONAL INFUSION CENTER ASSOCIATION

The Nation's Advocacy Voice for In-Office Infusion

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May 3, 2021

The Honorable Frank Pallone
2107 Rayburn HOB
Washington, DC 20515

The Honorable Richard Neal
372 Cannon House Office Building
Washington, DC 20515

The Honorable Bobby Scott
2328 Rayburn House Office Building
Washington, DC 20515

Re: H.R.3, the *Elijah E. Cummings Lower Drug Costs Now Act*

Chairman Pallone, Chairman Neal, and Chairman Scott:

The National Infusion Center Association (NICA) is a nonprofit organization formed to support non-hospital, community-based infusion centers caring for patients in need of infused and injectable medications. To improve access to medical benefit drugs that treat complex, rare, and chronic diseases, we work to ensure that patients can access these drugs in safe, more efficient and more cost-effective alternatives to non-hospital care settings. NICA supports policies that improve drug affordability for beneficiaries, increase price transparency, reduce disparities in quality of care and safety across care settings, and enable care delivery in the highest-quality, lowest-cost setting.

While we are keenly aware of the financial burden on patients created by high out-of-pocket drug costs, we are concerned that H.R.3 will have inadvertent downstream effects on the supply chain for infused medicines and on patients' ability to access innovative treatments in the most cost-effective setting. Infusion centers play a critical role in the delivery of specialty medications by offering a high-quality, low-cost setting for provider-administered medications. The data demonstrate that infusion centers save money within the healthcare system compared to hospital outpatient departments and even, in many cases, compared to the home.[1]

The Employee Benefit Research Institute recently looked at cost differences in healthcare services by site of treatment, including for the delivery of specialty medications. While the prescription drug pricing reform effort in H.R.3 focuses solely on the price of medications, the EBRI report found that, "[I]f site-of-

[1] UnitedHealth Group Report: "Reducing Specialty Drug Costs" (Sept. 9, 2019).

treatment price differentials for specialty medications were eliminated, employers and workers would save as much as 36 percent, depending on the medication."[2]

Specifically, the report looked at eight non-oncology, infused medications across a variety of conditions, including primary immunodeficiency, autoimmune disease (such as rheumatoid arthritis), multiple sclerosis, and supportive cancer care. These are the products that NICA members safely and consistently administer every day to patients across this country. For seven of the eight drugs, EBRI found that the hospital outpatient department had the largest allowed charges of any of the three settings (hospital, physician's office, home). In some cases, the hospital outpatient department charges were *more than double* those of office-based administration. This has an impact on our overall drug spending, but it also impacts patients, whose coinsurances reflect these price differentials.

We'd be remiss not to highlight that the disparity of these charges becomes even more outrageous when one considers that many hospitals have access to deep drug discounts under the 340B drug discount program, a program in which independent infusion centers cannot participate. According to the American Hospital Association, these discounts can reach 50%. A Milliman study found that, on average, 340B hospitals "receive reimbursements of 294% of their respective acquisition costs[.]"[3] Despite these deep discounts that no other infusion provider has access to, hospital-based infusion remains the most expensive option for patients and a leading driver in medical benefit spend, including Medicare Part B as the largest payer of medical benefit drugs.

Although office-based and freestanding infusion centers play a key role as the most efficient setting for drug administration, there is no facility fee for infusion centers. Instead, our members' reimbursement consists of administration codes, which grossly undervalue the real cost of services, and drug payments to offset losses on the professional services side. Thus, our members already run lean operations to meet the narrow margins and rely on their drug payments to maintain the economic viability of their practices. Significant reductions or interruptions to reimbursement – in the absence of a supplemental payment or increased professional service reimbursement to keep providers whole – will exacerbate the underlying cost-reimbursement disparity and reimbursement volatility. The delivery channel does not have the capacity to meet demand for biopharmaceutical products currently on the market, let alone those in the pipeline. We cannot afford to lose capacity as we work toward further integrating infusion therapies for

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[2] EBRI Issue Brief No. 525: "Location, Location, Location: Cost Differences in Health Care Services by Site of Treatment — A Closer Look at Lab, Imaging, and Specialty Medications" by Paul Fronstin, Ph.D., Employee Benefit Research Institute, and M. Christopher Roebuck, Ph.D., RxEconomics, LLC (Feb. 18, 2021).

[3] Milliman White Paper, "Analysis of 340B hospitals' outpatient department acquisition cost and commercial reimbursement for physician-administered brand medicines" by Anna Bunger, FSA, MAAA, Michael T. Hunter, PharmD, and Carol Kim (Dec. 2019).

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high risk COVID-19 positive patients, and integrate innovative first-line treatment options for complex diseases that have been difficult or impossible to treat with conventional drugs, like Alzheimer's disease. Unfortunately, H.R.3 includes no such offsetting payment and would therefore present detrimental consequences to infusion providers, as they could not absorb these untenable losses.

Additionally, while the legislation attempts to ensure that providers who purchase medications can access the "maximum fair price," there is no guarantee that these prices will keep providers whole in the absence of a supplemental payment to cover losses associated with their previous drug margins. Even so, the bill mandates that providers assess coinsurance against the maximum fair price. We are deeply concerned that these prices will leave providers underwater for the acquisition of infused medications and patients with no lower-cost alternative to hospital care settings.

In light of these concerns, we must oppose H.R.3 in its current form. We are eager to work with you to pursue site-of-care policies that support the preservation, optimization, and expansion of capacity among our lowest cost channel for medical benefit drugs, and empower patients to access the right medication at the right time in the most cost-effective settings. Please do not hesitate to reach out if we can provide any additional information.

Sincerely,

Brian Nyquist, MPH
Chief Executive Officer
National Infusion Center Association