August 17, 2026

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

Submitted electronically to: drugs@finance.senate.gov

Re: Request for Information: Commonsense Policy Options to Lower Drug Prices for Patients

The Infusion Providers Alliance (IPA) appreciates the opportunity to comment on the Request for Information: "*Commonsense Policy Options to Lower Drug Prices for Patients*," released by Senate Finance Committee Ranking Member Ron Wyden and other Senate Democrats.

The IPA's primary focus is ensuring that Medicare beneficiaries and all patients have appropriate and timely access to complex biologic Part B therapies. Our members deliver drug infusion and injection services in more than 1,000 community-based, non-hospital sites across 45 states. These community-based sites offer patients greater convenience while lowering costs for patients, Medicare, and the broader healthcare system. Preserving access to these lower-cost settings is critical to achieving Congress's affordability goals because site-of-care migration to higher-cost hospital outpatient departments increases both federal spending and beneficiary cost-sharing.

For example, under the proposed 2027 payment rates issued by the Centers for Medicare & Medicaid Services (CMS), Medicare would pay nearly $250 less for the first hour of a complex drug infusion furnished in a physician office or freestanding infusion center than in a hospital outpatient department (HOPD) for the same drug and administration service.[1] Beneficiary coinsurance is also lower in these sites of service.

IPA member facilities are major access points for care in communities large and small. Located where patients live and work, they provide flexible, convenient access to treatment

[1] See "Medicare Rate Comparison for Drug Administration Codes (CMS Proposed for 2027)," pg. 3.

for conditions such as Crohn's disease, ulcerative colitis, multiple sclerosis, rheumatoid arthritis, Alzheimer's disease, and many other complex and rare conditions. Studies have shown that, when clinically appropriate, these settings deliver high-quality care with clinical outcomes comparable to or better than hospital outpatient departments (HOPDs), but at significantly lower costs.[2,3]

IPA shares the goal of lowering healthcare costs and ensuring affordability. Providing lower-cost, high-quality care is what our members do every day within their infusion centers and physician offices across the country. As the Committee considers policy options and future legislation, preserving patient access to community-based settings and providers' ability to safely deliver complex therapies should be a principal consideration. Policies that inadvertently weaken community-based infusion providers risk accelerating provider consolidation and shifting care to higher-cost hospital settings, ultimately increasing costs for both Medicare and patients.

We appreciate the opportunity to provide feedback and look forward to working with the Committee as you refine policy options outlined in the RFI.

IPA's feedback to the RFI focuses on three specific issues.

1. Addressing Price-Linked Compensation
2. Policy Ideas to Help Boost the Biosimilar Market and Address "Underwater Biosimilar" Dynamics
3. Games & Abuses Due to Vertical Integration: White Bagging of Provider-Administered Drugs

Senate Democrats request feedback on policy options that would "delink" physician compensation from drug prices under Medicare Part B.

As the Committee is aware, providers administering Part B drugs in community-based settings receive two payments from Medicare: 1) a professional fee paid through the physician fee schedule and 2) an "add-on" payment based on 4.3 percent of the underlying average sales price (ASP) of the drug being administered.

IPA would like to highlight and underscore the severe inadequacy of the drug administration fee in the physician fee schedule, which does not cover anywhere near the resources needed to provide drug infusions in physician offices and ambulatory infusion

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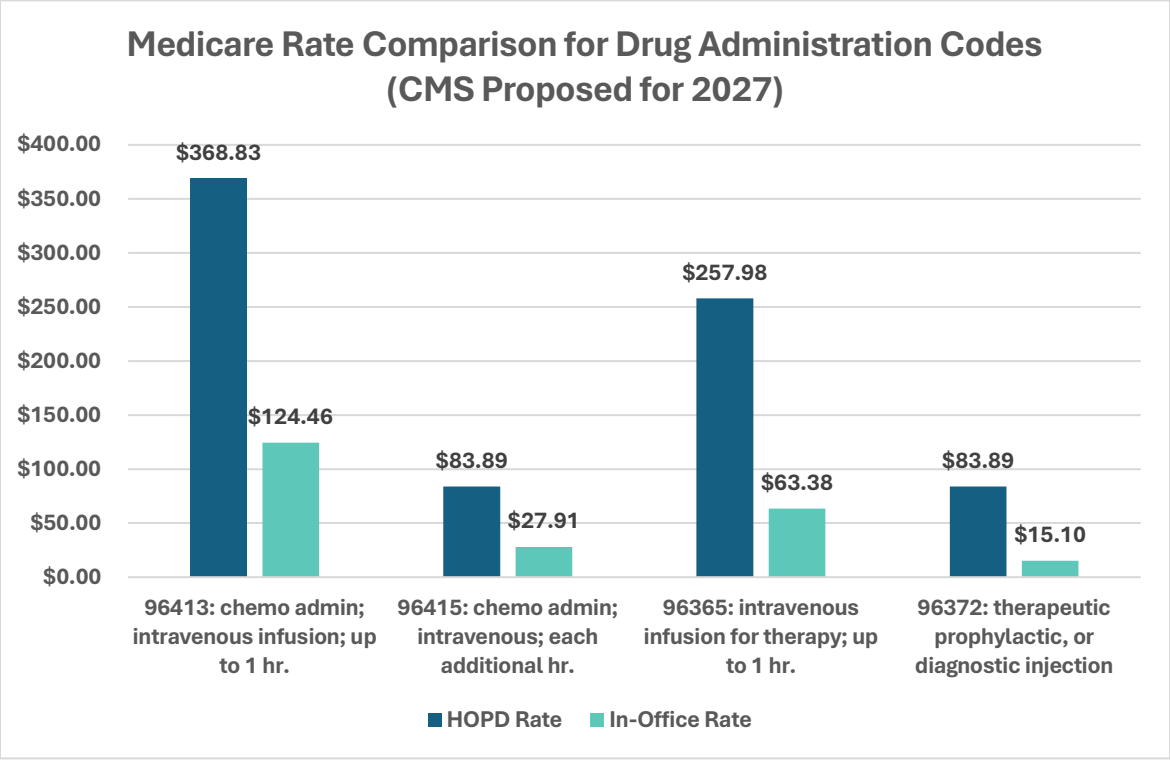
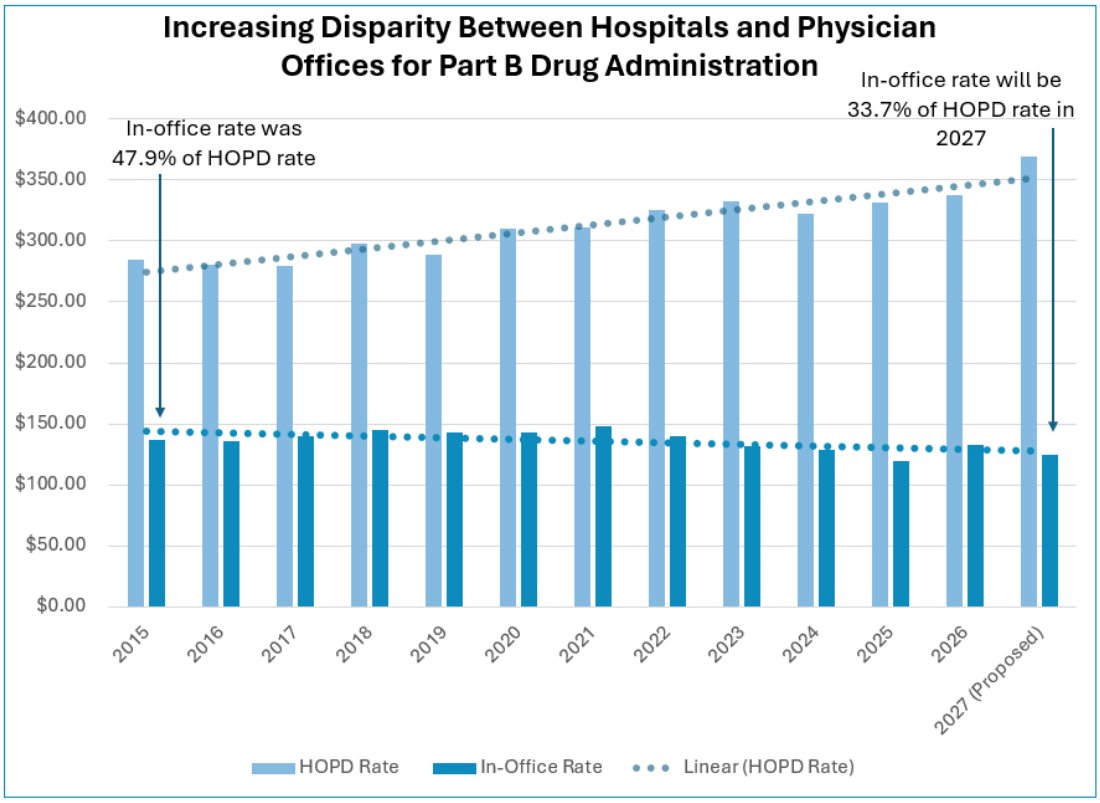
[2] Journal of Clinical Pathways, "Comparison of Specialty Injection and Infusion Adverse Events Among Hospital Outpatient Settings vs Non-Hospital Outpatient Settings" (2025), https://www.hmpgloballearningnetwork.com/site/jcp/original-research/comparison-specialty-injection-and-infusion-adverse-events-among.

[3] Journal of Managed Care & Specialty Pharmacy, "Infusion Therapy Patient Outcomes Are Similar at Reduced Costs" (Dec. 20, 2025), https://www.jmcp.org/doi/10.18553/jmcp.2025.25264.

centers. Set at just $133 in 2026 for the first hour of a complex drug infusion, it covers a small fraction of the cost of drug administration delivery. Furthermore, under the calendar year (CY) 2027 Hospital Outpatient Prospective Payment System (OPPS) and Physician Fee Schedule (PFS) proposed rules, professional fee payments to physician practices and freestanding infusion clinics are slated to decline approximately 6.6 percent in 2027 to $124 while payments to hospitals providing identical drugs are slated to substantially increase from $331 to $369. This growing disparity in payments between the two sites of care continues a decade-long trend of comparative drug administration fee erosion between the two sites of care from 47.9 percent in 2015 to 33.7 percent in 2027. This growing disparity is not merely a provider reimbursement concern. It creates a powerful economic incentive for consolidation and site-of-care migration. As independent physician practices and freestanding infusion centers face increasing financial pressure, patients are more likely to receive care in hospital outpatient departments where Medicare spending and beneficiary out-of-pocket costs are substantially higher. Preserving viable lower-cost alternatives should be a priority for policymakers seeking to reduce healthcare expenditures.





Data based on Code 96413: Chemotherapy administration intravenous infusion, up to one hour
Sources: HOPD Rate = Hospital Outpatient PPS: Addendum B / In-Office Rate = PFS Search

For these reasons, the current "add-on" payment for Part B drugs is absolutely critical to the ability of our providers to administer these products safely and efficiently. While these add-on payments are linked to the price of the drug, for more than a decade the 6 percent add-on payment enacted in the Medicare Modernization Act of 2003 has been reduced to just 4.3 percent due to sequester and will continue at that reduced level for the foreseeable future.

Moreover, we underscore that IPA members and independent physician practices do not have access to 340B discounts, which averaged 59 percent in 2023 and are projected to exceed 60 percent by 2027.[4] Annual 340B purchases increased from $6.6 billion in 2010 to $100 billion in 2025.[5] The add-on payment is materially less consequential for 340B hospitals, given their substantial acquisition discounts, but remains essential for low-margin physician practices and freestanding infusion centers. Payment policies that fail to recognize these fundamentally different acquisition economics risk further distorting

[4] Berkeley Research Group, "340B Program at a Glance: 2025" (2025), 340B-Program-at-a-Glance-2025_F.pdf.
[5] Health Resources and Services Administration, "2025 340B Covered Entity Purchases" (July 2026), https://www.hrsa.gov/opa/updates/2025-340b-covered-entity-purchases.

competition between hospitals and independent providers and accelerating consolidation into more expensive sites of care.

The Committee's RFI notes, "the linkage between the Part B add-on payment and drug prices may create incentives for physicians to prescribe more expensive medicines in some cases." It is important to highlight that many of our member companies have no control over which drugs are prescribed and simply administer a prescribing physician's order when a patient is referred to their facility. In these cases, the administering facility has no control over the prescribed product, and the prescribing physician does not share in the administering facility's drug reimbursement.

The add-on payment is intended to help compensate providers for the infrastructure and complexity of drug delivery. This can include, but is not limited to, cold-chain handling, extended chair time, reaction monitoring, specialty-trained nursing, revenue-cycle burden, inventory carrying cost, rent, utilities, and employee benefits and taxes. Unfortunately, utilizing the professional fee alone for drug administration covers a small fraction of a provider's actual cost of delivering infused and injected therapies. The add-on payment is therefore essential and currently provides the principal source of reimbursement supporting this delivery infrastructure and complexity. The add-on portion of reimbursement for physicians and infusion clinics is the reason those patient access points can provide care and compete with hospitals.

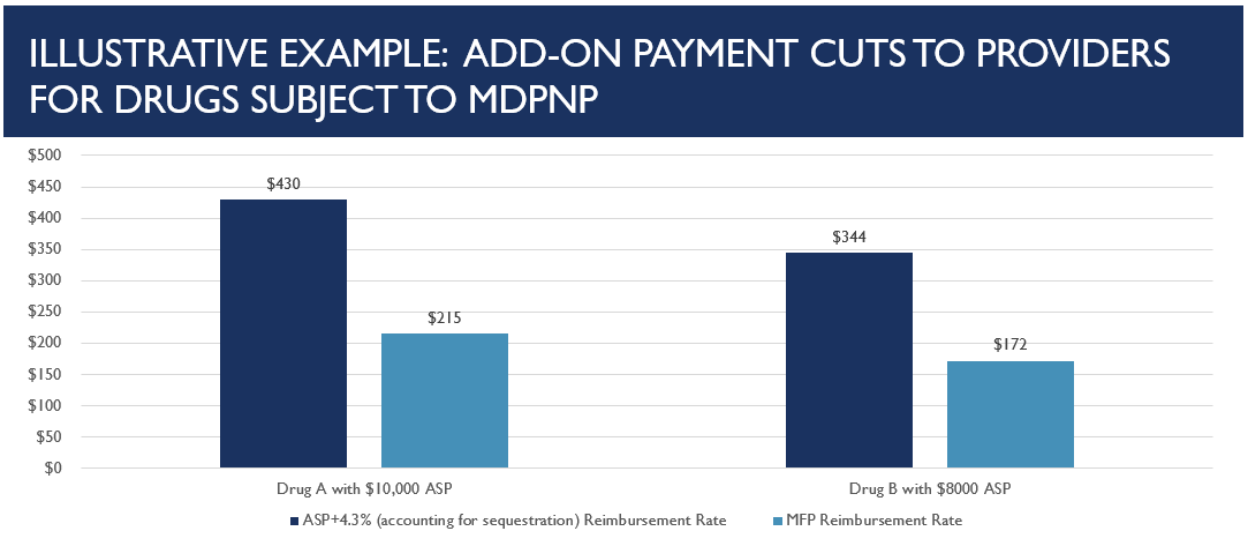
The Impact of the Medicare Drug Price Negotiation Program on Infusion Providers and Other Clinicians Administering Part B Drugs

Beginning in 2028, Part B drugs will become subject to negotiation under the Inflation Reduction Act's (IRA) Medicare Drug Price Negotiation Program (MDPNP). Under current law, the basis for calculating Medicare reimbursement for selected Part B drugs will shift from Average Sales Price (ASP) plus 6 percent, an effective 4.3 percent after sequestration, to Maximum Fair Price (MFP) plus 6 percent. Because the provider add-on payment would be calculated using the substantially lower MFP, provider add-on reimbursement would fall commensurately.

A top priority for the IPA is ensuring that patients and providers do not become collateral damage in government negotiations with pharmaceutical manufacturers. Specifically, the IPA and the entire provider community are unified on preserving the ASP benchmark for the purposes of calculating provider reimbursement. The Congressional Budget Office (CBO) projects that net prices for drugs selected for negotiation could decline by as much as 50 percent.[6] For selected Part B drugs, a comparable reduction from ASP to MFP would

[6] CBO, Letter to Chairmen Jodey Arrington, Brett Guthrie, and Jason Smith (July 29, 2026), https://www.cbo.gov/system/files/2026-07/62549-Medicare-Part-D.pdf.

reduce the associated add-on payment by the same percentage. For example, if a drug's ASP is $10,000 and its negotiated MFP is $5,000, the provider add-on payment would fall from $430 to $215. Cuts of this magnitude could threaten patient access. Patients could experience longer wait times, increased travel burdens, disruptions in care continuity, and greater reliance on hospital-based treatment settings. The resulting shift toward higher-cost sites of care would undermine many of the affordability gains Congress seeks to achieve through the MDPNP.



As additional Part B drugs become subject to negotiation, these reimbursement reductions and implementation complexities could threaten provider financial stability and patient access, particularly in community-based settings that already operate with limited reimbursement for drug administration services.

How H.R. 4299, the Protecting Patient Access to Cancer and Complex Therapies Act Addresses These Issues

H.R. 4299, the Protecting Patient Access to Cancer and Complex Therapies Act, was introduced by Representatives Greg Murphy (R-NC), Adam Gray (D-CA), and Neal Dunn (R-FL). The bipartisan legislation currently has support from more than 40 members of the House and would provide a targeted fix to these unintended consequences while maintaining the Medicare savings and beneficiary affordability associated with the MDPNP. It is intended to protect providers from reimbursement reductions resulting from negotiations between manufacturers and the federal government, preserve access to lower-cost community-based care, and maintain lower beneficiary coinsurance. Importantly, the legislation would preserve the economic viability of community-based infusion providers

that routinely furnish care at significantly lower cost than hospitals. By protecting access to these settings, the bill supports both patient affordability and Medicare savings.

The legislation has three primary components:

- Provider reimbursement for negotiated Part B drugs would remain based on ASP plus 6 percent, an effective 4.3 percent after sequestration.
- Beneficiary coinsurance would continue to be calculated using the lower MFP-plus 6 percent payment amount established under the IRA.
- Manufacturers would pay CMS a rebate equal to the difference between the ASP-based provider reimbursement amount and the MFP-based amount, preserving Medicare's savings from the negotiated price. Milliman estimates that manufacturers would bear greater costs under this approach than under the IRA as enacted.[7]

Rather than achieving savings through reductions in provider reimbursement, H.R. 4299 would utilize manufacturer rebates, a familiar mechanism employed throughout government and commercial healthcare programs. For example, the Medicaid Drug Rebate Program (MDRP) has operated for more than three decades, the IRA utilizes rebates for prescription drug price increases that exceed inflation (CPI), and the proposed Global Benchmark for Efficient Drug Pricing (GLOBE) Model similarly relies on a rebate approach while maintaining the existing ASP-based provider reimbursement methodology. Rebates are a common tool used by the government and private payers. Under H.R. 4299, this approach would not cause disruption to providers and beneficiaries. Instead, it would maintain lower beneficiary coinsurance, protect patient access, and preserve existing provider reimbursement.

Importantly, H.R. 4299 would not remove any products from negotiation, delay the implementation of negotiated prices, or extend product exclusivity periods. It would instead protect patients and providers from unintended consequences arising from negotiations between manufacturers and the federal government while preserving the program's savings and beneficiary affordability objectives.

H.R. 4299 has broad support from a diverse coalition of 67 patient and provider organizations representing individuals living with cancer, autoimmune disorders, rare diseases, and other serious conditions.[8] This consensus reflects shared concern that, without targeted policy adjustments, the effectuation of negotiated prices in Part B may

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[7] Milliman, "Impact of the Inflation Reduction Act on Part B Provider Payment and Patient Access to Care" (May 2025), https://media.milliman.com/v1/media/edge/images/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2025-Articles/5-9-25_IRA-Provider-Impact_Full-Report.pdf.

[8] Infusion Providers Alliance, "IPA Joins 67 Patient & Provider Organizations in Support of Bipartisan Bill to Protect Patient Access to Cancer and Complex Therapies" (Aug. 22, 2025), https://www.infusionprovidersalliance.org/ipa-joins-patient-provider-organizations-in-support-of-bipartisan-bill-to-protect-patient-access-to-cancer-and-complex-therapies/.

inadvertently limit treatment options and reduce timely access to care. Policies that safeguard access to complex therapies while maintaining the stability of lower-cost, community-based care are essential to achieving Congress's affordability and cost-of-care objectives. Policies that preserve and support access to these alternative sites of care are therefore critical to maintaining patient access, safety, and system-wide affordability and should be prioritized, especially as favorable reimbursement for hospital-owned sites has been shown to encourage hospitals' acquisition of physician practices.[9]

H.R. 4299 would address the imminent consequences of implementing negotiated Part B prices under the current reimbursement framework. Passage of the legislation is necessary to ensure patient access as Congress considers longer-term reforms and policy options that could "delink" physician compensation from drug prices under Medicare Part B.

Reforming the Price-Based Add-on Payment

As noted, the add-on payment is essential for providing sufficient resources to administer Part B drugs. IPA is prepared to work with the Committee, other stakeholders, and Congress on ideas to reform the add-on payment that preserve the resources needed today and in the future to meet the financial, operational, and clinical demands associated with novel, high-cost therapies. We recommend providing sufficient time (e.g., a minimum of five years) to work with stakeholders and CMS to ensure a smooth transition from the current payment system to a new methodology that treats stakeholders equitably and predictably and ensures continued patient access.

Previous policy proposals noted in the RFI, advanced by the Obama Administration, the Medicare Payment Advisory Commission (MedPAC), and the first Trump Administration, would have removed substantial resources needed to support Part B drug administration, particularly for those with resource-intensive drug administration requirements, and could have jeopardized patient access. IPA does not support the flat-fee, capped-payment, or hybrid percentage-and-flat-fee proposals described in the RFI because they would remove substantial resources from community-based providers and fail to adequately account for resource and clinical complexity differences between drugs and growth in practice costs. Importantly, these proposals would not simply redistribute reimbursement. They could reduce provider participation in Part B drug administration and increase reliance on hospital-based care, potentially resulting in higher overall spending despite lower payment rates in physician offices.

In many communities, hospitals are already experiencing infusion chair capacity constraints. IPA members increasingly receive referrals from hospitals that lack the

[9] U.S. Government Accountability Office, "Health Care Consolidation: Published Estimates of the Extent and Effects of Physician Consolidation" (September 22, 2025), https://www.gao.gov/products/gao-25-107450.

capacity to accommodate additional patients. These pressures are expected to increase, and policies that reduce community-based provider capacity would only worsen the patient access challenges Congress should be working to prevent.

Any policy that reduces the aggregate resources available for Part B drug administration through the Part B add-on payment, whether through scheduled MFP-based reimbursement reductions, expansion of the Secretary's negotiation authority that results in more drugs becoming subject to negotiation or drugs becoming subject to negotiation more rapidly, steeper reimbursement reductions due to international benchmarking, or misguided add-on payment reforms (such as those advocated by MedPAC) that fail to account for downstream consequences, risks worsening existing capacity constraints and limiting patient access. Unlike hospitals, which can rely on multiple revenue streams, including inpatient care, outpatient surgery, diagnostics, foundation support, and more, if drug administration payments are constrained, freestanding infusion centers have no other lines of business, and physician practices have limited ability to offset losses through other services.

In short, IPA is prepared to work with Congress on reforms to add-on payments currently linked to drug prices, so long as the reforms do not reduce aggregate resources available in the system, are developed with sufficient stakeholder input, treat stakeholders equitably, and safeguard patient access.

Policy ideas that would help boost the biosimilar market and address "underwater biosimilar" dynamics

The RFI requests policy ideas to help boost the biosimilar market and address anticompetitive rebate strategies in Medicare Parts B and D. One significant barrier to realizing the promise of biosimilars is the challenge of "underwater biosimilars." Under current reimbursement policies, certain provider-administered biosimilars are reimbursed below providers' acquisition costs due to market dynamics that artificially depress ASP. Many insurers and their PBMs have exerted disproportionate sway on drug formularies by pressuring pharmaceutical companies to offer significant rebates to the insurance payors in exchange for preferred formulary placement. Rebates are reflected in manufacturers' quarterly ASP reporting to CMS, thereby depressing ASP and, in some cases, causing Medicare and private health plan reimbursement to fall below providers' acquisition costs. Providers receive none of the rebate dollars that contribute to the lower ASP, yet those rebates still reduce the reimbursement they receive. As a result, many providers' acquisition costs substantially exceed Medicare and other private health plan payments for these products, creating barriers to patient access and further threatening the viability of delivering these therapies in community-based settings. These dynamics create a troubling paradox: providers seeking to furnish lower-cost biosimilars may face financial penalties

for doing so. Congress cannot expect widespread biosimilar adoption when reimbursement falls below acquisition cost. If policymakers are serious about lowering drug spending, reimbursement policies should reward, rather than discourage, the utilization of clinically appropriate lower-cost alternatives.

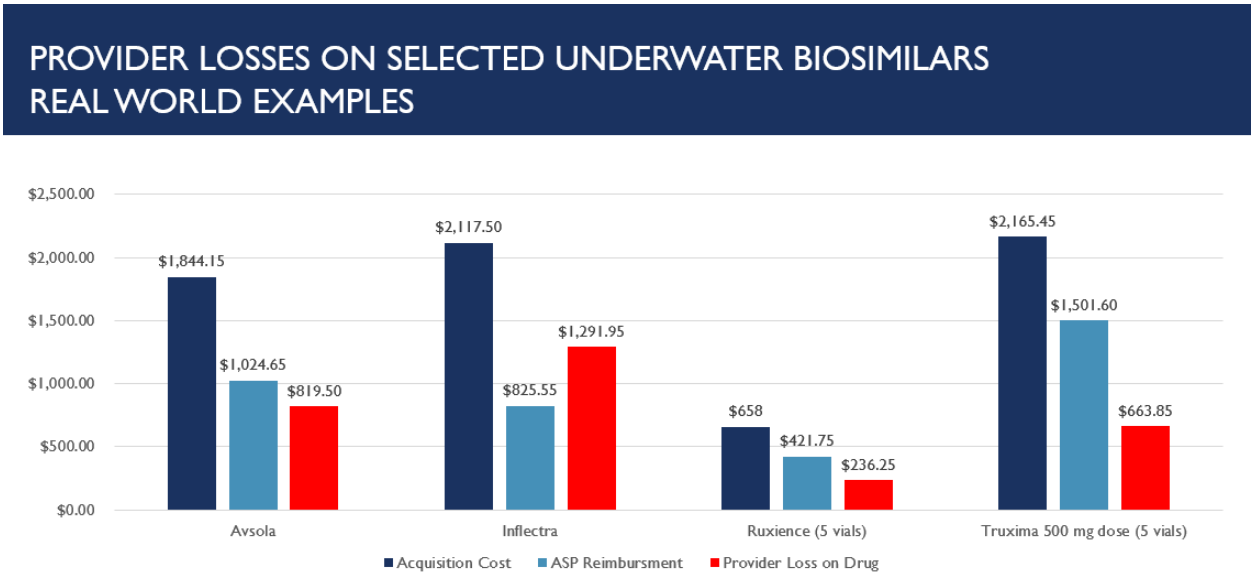
IPA, along with other provider and patient organizations, has called on Congress to address this reality.[10] We have advocated for the following solutions:

- Amend Section 1847A to extend the Secretary's authority to use wholesale acquisition cost (WAC) + 3 percent until ASP reaches sustainable levels, as determined by the Secretary.
- Amend Section 1847A(c)(3) to remove from ASP calculations the rebates negotiated between PBMs and drug manufacturers.
- Call for CMS to either withdraw the 2018 memorandum "Prior Authorization and Step Therapy for Part B Drugs in Medicare Advantage," or at a minimum, revise the step therapy memo to clarify that beneficiaries should have access to an alternative biosimilar or reference product when the step therapy-preferred biosimilar is not financially viable for physicians to administer.

IPA previously provided additional information and real-world examples from our members to Congress in advance of the House Ways & Means Subcommittee on Health's April 2025 hearing, "*Lowering Costs for Patients: The Health of the Biosimilar Market*."[11]

[10] Infusion Providers Alliance, "IPA Joins 40+ Patient and Provider Groups in Letters to Congress and the FTC Detailing Dynamics Impacting Access to Biosimilars" (June 4, 2025), https://www.infusionprovidersalliance.org/ipa-joins-40-patient-and-provider-groups-in-letters-to-congress-and-the-ftc-detailing-dynamics-impacting-access-to-biosimilars/.

[11] Infusion Providers Alliance, "Comments & Recommendations on 'Lowering Costs for Patients: The Health of the Biosimilar Market'" (Apr. 14, 2025), https://www.infusionprovidersalliance.org/wp-content/uploads/2025/04/Infusion-Providers-Alliance-WM-Biosimilar-Hearing-Comments-FINAL-Submitted.pdf.



Additionally, we recommend initiating a shared savings program to encourage greater biosimilar adoption whereby providers would receive a percentage (e.g., 35 percent) of the spread between an innovator product and a lower-cost biosimilar product. Unlike reimbursement reductions or utilization controls, a shared-savings model would directly align provider incentives with Congress's objective of increasing uptake of lower-cost biosimilars and reducing overall spending. In this way, prescribing providers could be incentivized to select lower-cost Part B products rather than more expensive products, when clinically appropriate. This program could commence in 2032 when the existing additional add-on payment (8 percent) is scheduled to expire.

Games & Abuses Due to Vertical Integration: White Bagging of Provider-Administered Drugs

The RFI also notes the perverse incentives, games, and abuses that arise from the vertical integration of the supply chain. IPA shares this concern.[12] IPA recognizes that the Committee's separate *Health Coverage That Works for Everyone* RFI more directly addresses private insurance practices, administrative barriers, and vertical integration. IPA has serious concerns about business practices arising from the vertical integration of insurers, PBMs, specialty pharmacies, and other subsidiaries that raise costs and harm patient access, including specialty pharmacy mandates, sometimes referred to as "white bagging," and self-administration mandates imposed contrary to patient preferences or the clinical judgment of treating physicians. These practices can undermine continuity of care, increase administrative burden, and interfere with treatment decisions made by patients and their

[12] Infusion Providers Alliance, "IPA Submits Comments to E&C and W&M Ahead of Hearings with Health Insurance CEOs" (January 22, 2026), https://www.infusionprovidersalliance.org/ipa-submits-comments-to-ec-and-wm-ahead-of-hearings-with-health-insurance-ceos/.

physicians. IPA will provide additional recommendations through the Committee's separate RFI process on insurer-mandated specialty-pharmacy sourcing and related issues.

Conclusion

IPA appreciates the Committee's focus on identifying practical solutions to lower healthcare costs and improve affordability for patients. As Congress evaluates reforms to Medicare Part B payment, biosimilar competition, and market incentives, these efforts should not weaken the lower-cost, community-based provider infrastructure that helps make care more affordable. As an immediate priority, Congress should address the unintended provider reimbursement and patient access consequences of negotiated Part B prices through the **Protecting Patient Access to Cancer and Complex Therapies Act**. Any longer-term reform to the Part B add-on payment should preserve the aggregate resources necessary to safely administer complex therapies and avoid shifting care to higher-cost hospital settings.

Congress should also address reimbursement dynamics that can make lower-cost biosimilars financially unsustainable for providers and market distortions arising from vertical integration that interfere with patient and provider choice. Policies that strengthen competition, preserve access to community-based infusion services, and support lower-cost sites of care can reduce costs for patients and taxpayers without sacrificing access or quality. IPA stands ready to work with the Committee and other stakeholders on these issues.

Thank you for the opportunity to provide feedback on this important RFI.

Sincerely,

Elliott Warren
Executive Director
Infusion Providers Alliance