

Pricing & Reimbursement

2021

Fourth Edition

Contributing Editor: **Grant Castle**

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USA

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Abstract

The United States (“U.S.”) accounts for the largest share of drug spending and innovation in the world, and its drug pricing regime is the most complex given its multi-payer model and unique overlay of market access requirements that collectively impact drug pricing and reimbursement decisions in the U.S.

The U.S. health care system includes both private and public health insurance coverage. Whether a drug product is covered, and at what price, is determined by each payer’s coverage, coding, and payment criteria for health insurance plans. The largest government-funded programs are Medicare and Medicaid, under which plans are subject to detailed requirements set forth by statute or regulation. Private plans, which cover far more Americans than public plans, have more flexibility to make coverage and reimbursement determinations. All plans implement various cost containment measures which may impact plan beneficiaries’ access to certain drug products. For Americans that either do not have insurance or have inadequate coverage to support their drug purchasing needs, a number of public safety net programs or private assistance programs (including manufacturer assistance) may be available to ensure access to needed medications.

Drug prices are highly dependent on the complexities of the U.S. drug supply chain. Between the initial manufacturing and ultimate dispensing of a given drug product, numerous transactions must take place among manufacturers, wholesalers, pharmacies, pharmacy benefit managers (“PBMs”), providers, and payers. These transactions typically involve price concessions in the form of discounts or rebates, as well as other fees. As a result, there is a significant gap between the list price a manufacturer initially sets for a drug product, and what is sometimes referred to as the “net price” – the actual amount of money received by the manufacturer.

Successful market access requires navigating this complex pricing and reimbursement system in a way that ensures drug products are available to patients, reimbursable by patients’ private or public plans, and appropriately valued to ensure favorable coverage. These efforts also must comply with overlapping regulatory requirements and minimize risk related to enforcement action for violating regulatory or compliance obligations. Manufacturers should be aware of policy proposals and emerging trends that may significantly affect drug pricing and reimbursement in the U.S.

Market introduction/overview

The U.S. health care market

Health insurance

The U.S. health care system consists of a complex mix of payers and institutions.

Government-funded programs include Medicare (a federal program that primarily covers individuals 65 years of age and over) and Medicaid (a joint federal-state program that provides coverage for individuals with limited income and resources), as well as programs for military personnel, veterans, uninsured children, and others. Private health insurance, which covers 68% of the population, is more prevalent than public health insurance.¹ Most private insurance is offered through employer-sponsored plans, although Americans can also purchase coverage directly. Coverage for prescription drugs is an important component of both private and government health insurance programs.

Over 90% of Americans have health insurance through such private or public plans, but a significant number of Americans do not have any form of health insurance coverage. In 2019, the latest year for which coverage data is available, the U.S. population of 324.5 million had coverage as follows:

- 221 million received coverage under private plans, including 183 million through employment-based plans;
- 58.8 million received coverage under Medicare;
- 55.9 million received coverage under Medicaid;
- 3.2 million received coverage through the Veterans Health Administration and the Civilian Health and Medical Program within the Department of Veterans Affairs, and TRICARE (previously known as Civilian Health and Medical Program of the Uniformed Services); and
- 26.1 million were uninsured.²

Underinsurance remains a significant challenge. Many Americans face relatively high out-of-pocket health care costs in the form of premiums, deductibles, coinsurance, and copayments required by private and government payers for covered services, as well as costs for services not covered by insurance. In 2017, more than 1 in 50 Americans who interacted with the health care system had out-of-pocket costs above \$5,000, and 1 in 200 had costs over \$10,000.³

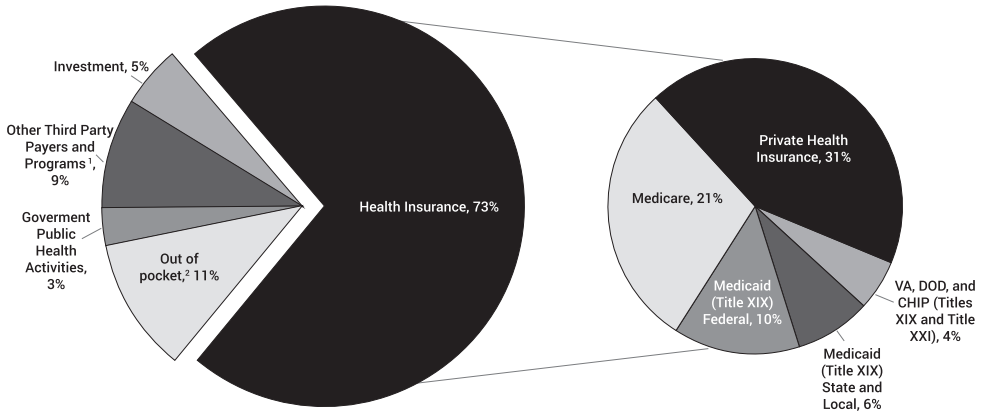
Although many developed nations choose to provide health care under a universal or single payer system, the U.S. has elected to use a multiple payer model combined with government- and privately run safety net programs and mandatory access to emergency care for all residents.⁴ In addition to funding Medicaid and other programs aimed at vulnerable populations, the federal government requires drug manufacturers to provide outpatient drugs to health care providers that primarily serve low-income and uninsured individuals under a program known as the 340B Drug Pricing Program. Private charitable foundations also provide financial assistance or free product to eligible patients who struggle to afford expensive prescription drugs.

Health care spending

The U.S. has the highest health care spending *per capita* in the world.⁵ *Per capita* spending has increased dramatically in recent decades, rising by 290% between 1980 and 2018.⁶ In 2019, health care spending grew 4.6% and accounted for 17.7% of the Gross Domestic Product (“GDP”).⁷

In 2019 alone, the U.S. spent approximately \$3.8 trillion on health care.⁸ Figures 1 and 2 show how health care spending breaks down across payers and services, as estimated by the Centers for Medicare & Medicaid Services (“CMS”).

Figure 1: The nation’s health dollar – where it came from⁹



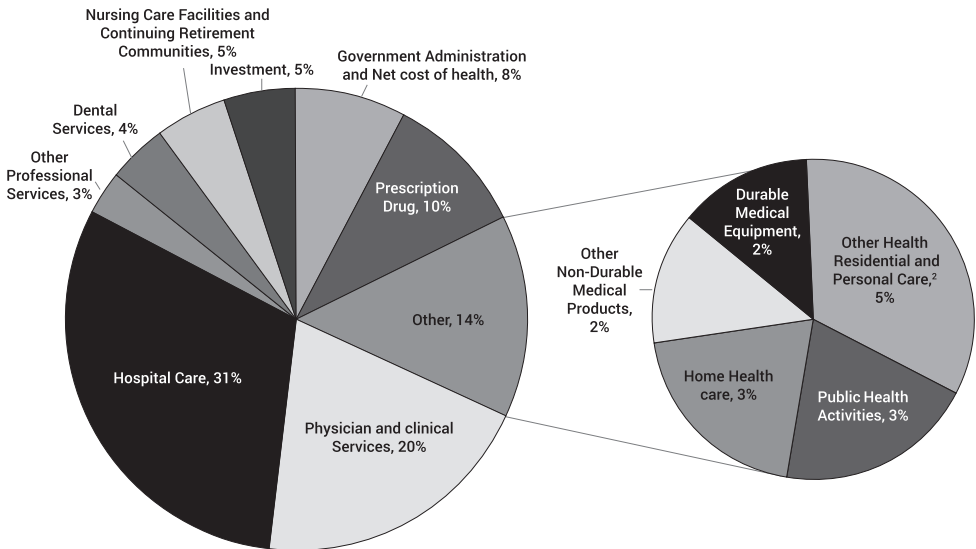
¹ Includes worksite health care, other private revenues, Indian Health Service, worker’s compensation, general assistance, maternal and child health, vocational rehabilitation, Substance Abuse and Mental Health Services Administration, school health, and other federal and state local programs.

² Includes co-payments, deductibles, and any amounts not covered by health insurance.

Note: Sum of pieces may not equal 100% due to rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of Actuary, National Health Statistics Group.

Figure 2: The nation’s health dollar – where it went¹⁰



¹ Includes Noncommercial Research and Structures and Equipment.

² Includes expenditures for residential care facilities, ambulance providers, medical care delivered in non-traditional settings (such as community centers, senior citizens centers, schools and military field stations), and expenditures for Home and Community Waiver programs under Medicaid.

Note: Sum of pieces may not equal 100% due to rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

As shown in Figure 2, CMS estimates that prescription drugs account for approximately 9% of health care spending. CMS estimates that, in 2019, prescription drug spending increased 5.7% to \$369.7 billion of the national health expenditures, faster than the 3.8% growth rate in 2018.¹¹ Some sources estimate that the percentage of spending on prescription drugs is actually closer to 15% of total spending, when accounting for non-retail drug sales as well as the gross profits of other parties in the drug supply chain, such as wholesalers, pharmacies, PBMs, providers, and payers.¹²

In part because of the federal dollars at stake, health care is the primary target of federal civil enforcement actions, including with respect to drug pricing and market access issues. In 2020, the federal government recovered more than \$2.2 billion in settlements and judgments under the False Claims Act (“FCA”), which prohibits persons from making false claims (or causing false claims to be made) to the government – \$1.8 billion related to health care cases, including those involving drug and medical device manufacturers, managed care providers, hospitals, pharmacies, hospice organizations, laboratories, and physicians.¹³ Previously, 2019 was the tenth consecutive year in which civil health care fraud recoveries exceeded \$2 billion.¹⁴ Additionally, the federal government utilizes the Anti-Kickback Statute (“AKS”) to combat activity that increases utilization and costs to federal programs, skews prescribing and other health care decisions, and creates an uneven competitor playing field.¹⁵ Navigating this enforcement landscape requires a sophisticated understanding of the FCA, AKS, and government price reporting laws, as well as corresponding state laws.

The cost of prescription drugs

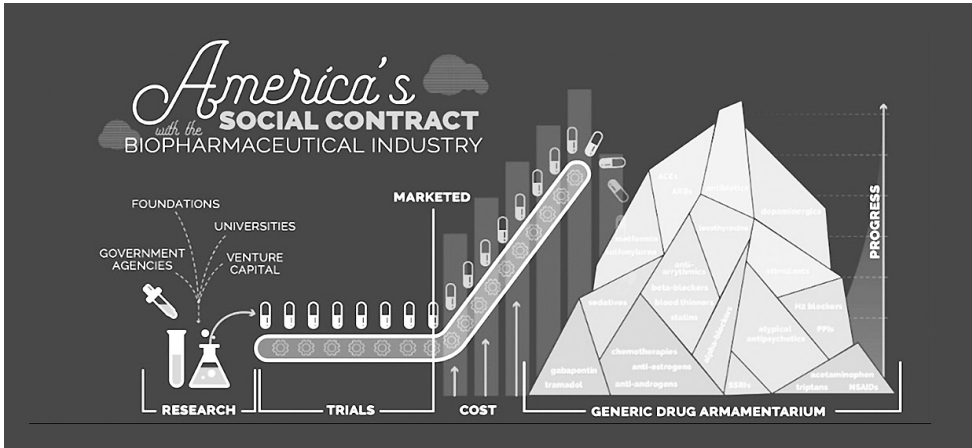
The high list price of prescription drugs in the U.S. is frequently discussed in the press and public discourse. Yet, the headlines often fail to capture both the types of drugs driving health care expenditures and the intricacies of the drug supply chain that create a significantly lower net price for a given drug product.

Branded versus generic drugs

Approximately 9 out of 10 prescriptions filled are for inexpensive generic drugs.¹⁶ Prescription drug spending is primarily driven by the price of on-patent drugs. In general, after 10–15 years, these branded drugs lose patent protection, and inexpensive generic versions enter the market. As illustrated in Figure 3, from Peter Kolchinsky’s article entitled “American’s Social Contract with the Biopharmaceutical Industry”, the high price of branded drugs supports a “growing mountain” of highly utilized generic drugs.¹⁷ Offering manufacturers higher prices for on-patent drugs for a limited period of time incentivizes innovation. The U.S. receives a return on its investment after the patent expires, at which point the drug rapidly declines in price. Payers encourage the utilization of generic drugs by implementing lower cost-sharing requirements.

See overleaf

Figure 3: America’s Social Contract with the Biopharmaceutical Industry¹⁸

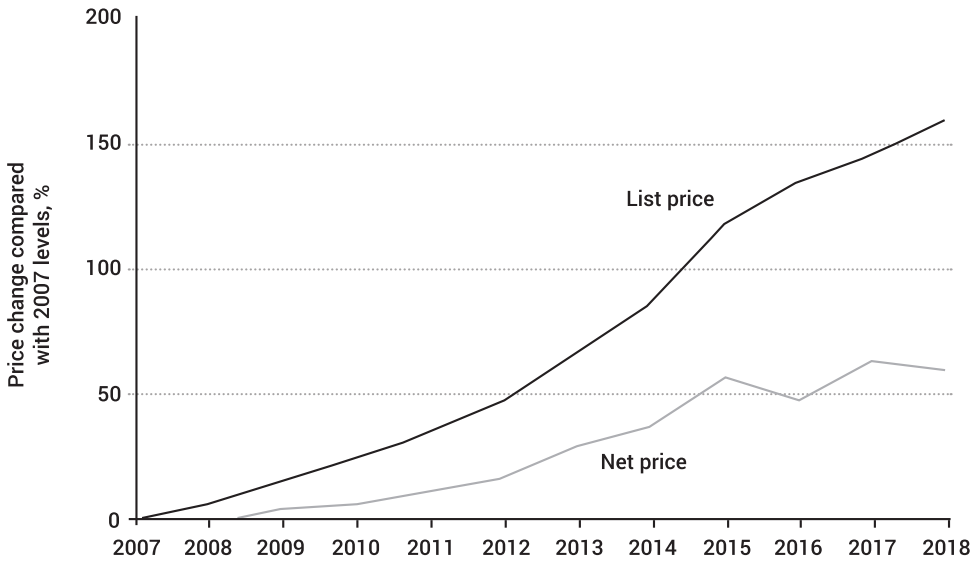


A small subset of branded drugs known as “specialty drugs” are a principal driver of prescription drug prices and expenditures. Medicare defines specialty drugs as pharmaceuticals costing \$670 or more per month,¹⁹ and other payers look at factors beyond price, designating products as specialty drugs if they (a) are novel therapies, (b) require special handling, monitoring, or administration, or (c) are used to treat rare conditions.²⁰ Specialty drugs account for approximately 2% of prescriptions but almost half of prescription drug spending.²¹ Further, specialty share of net prescription drug spending increased from 26.2% in 2009 to 49.5% in 2018.²² This trend is driven in part by innovation – specialty drugs represented the largest proportion of new drug products launched during this time period – and in part by patent expirations for traditional drug products.²³ In particular, cell and gene therapies represent the next frontier of specialty medications, with products such as chimeric antigen receptor T-cell (“CAR-T”) therapy presenting tremendous promise to treat cancer on a highly personalized level. Many of these innovative treatments are priced – or are expected, once approved, to be priced – above \$1 million for a course of treatment, but offer potential cures for otherwise fatal and/or debilitating conditions. Often, companion diagnostics and/or next generation sequencing tests are required as a prerequisite to accessing specialty drugs, and these tests have their own reimbursement and pricing dynamics.²⁴

List price versus net price

Figure 4 illustrates that there is a significant gap between the list prices often cited in policy debates on drug pricing and the net prices actually reflecting the amount of money manufacturers receive.

See overleaf

Figure 4: List price vs. net price²⁵

Changes from 2007 to 2018 in list and net prices for branded products that were available in January 2007 and for which U.S. sales were reported by publicly traded companies. Net prices are net of all concessions made by manufacturers including rebates, coupon cards, 340B discounts, prompt pay discounts, return provisions, and any other deductions captured in the reporting of net sales.

The gap between list price and net price reflects various price concessions, such as discounts and rebates, associated with the numerous transactions throughout the U.S. drug supply chain, including among entities such as manufacturers, wholesalers, pharmacies, PBMs, and payers. According to the Pew Charitable Trust, manufacturer rebates grew from \$39.7 billion in 2012 to \$89.5 billion in 2016, significantly offsetting increases to drug list prices.²⁶ The prevalence of additional fees, such as administrative and service fees required by PBMs, may also impact pricing considerations.

Global comparisons

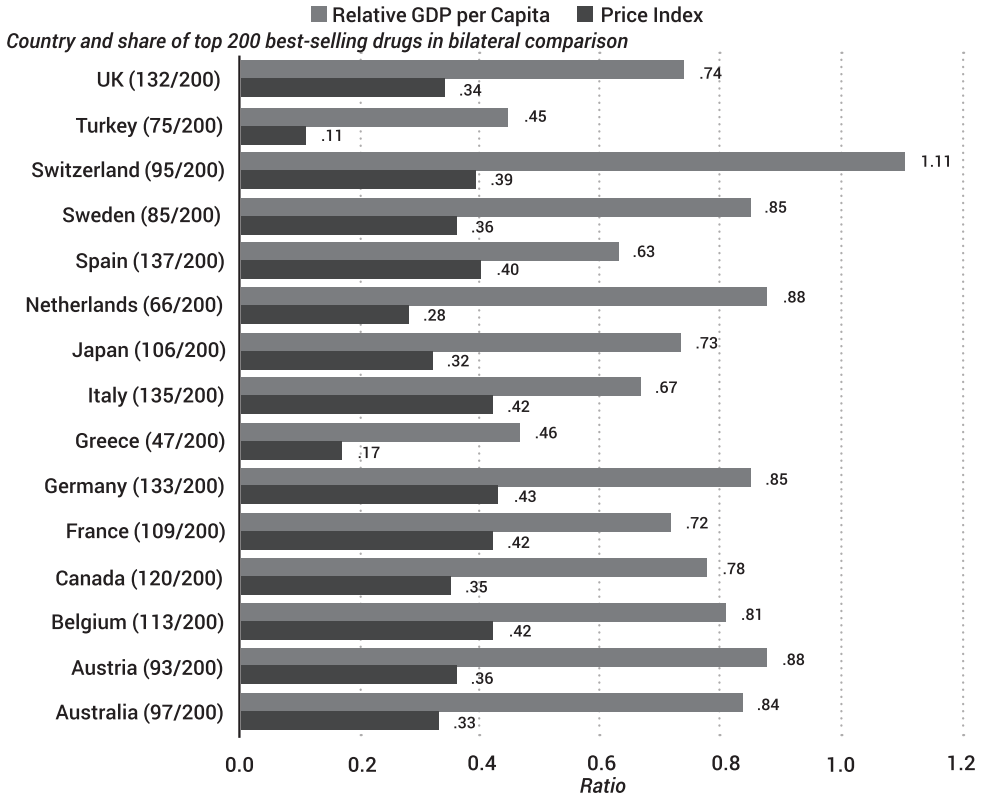
Health care spending in the U.S. far outpaces international averages. In 2019, national health care expenditures generated 17.7% of GDP (in comparison to the Organisation for Economic Co-operation and Development (“OECD”) average of 8.8%), totaling about \$11,582 *per capita* (in comparison to the OECD average of \$4,223.5).²⁷

Prices for prescription drugs are significantly higher in the U.S. in comparison to other industrialized nations. Figure 5, reproduced from a report by the Council of Economic Advisers (“CEA”), shows the U.S. Price Index for 200 top-selling prescriptions, as well as relative GDP *per capita*. As the chart demonstrates, observed patented drug prices are far higher in the U.S. than can be explained by differences in *per capita* income alone. A price index of 0.34, for instance, indicates that prices in the United Kingdom are 34% of those in the U.S., even though the GDP in the United Kingdom is 74% of that in the U.S.

On the other hand, as demonstrated in the parentheses along the y-axis, many of the 200 top-selling drugs are not available for sale in the countries of comparison. For example, in the United Kingdom, only 132 of the 200 drugs showed evidence of significant sales. Put another way, certain prescription drugs, such as some of the most innovative treatments for

cancer, are more readily available in the U.S. than they are abroad. In its analysis, the CEA states that “[t]he absence of significant sales volume for these drug products might be the result of delayed regulatory approval, a decision by a public insurance program not to cover a drug based on health technology assessment criteria, or other factors”.²⁸

Figure 5: Foreign-U.S. Price Index for 200 top-selling prescriptions and relative GDP per capita for selected nations, 2017²⁹



Pharmaceutical pricing and reimbursement

Marketing authorization

All drug products must be approved for use in the U.S. by the Food and Drug Administration (“FDA”), which is a government agency within the Department of Health and Human Services (“HHS”). FDA is charged with “protect[ing] the public health”, including by ensuring that drugs are safe and effective, and “promot[ing] the public health” by efficiently reviewing and approving new drug products.³⁰ Currently, there are over 20,000 prescription drugs approved for marketing in the U.S., as well as 300 FDA-licensed biological products.³¹

FDA approves new drugs and new uses of approved drugs on the basis of safety and effectiveness. Innovative drug products are approved through New Drug Applications (“NDAs”) and Biologics Licensing Applications (“BLAs”).³² Manufacturers must demonstrate substantial evidence of effectiveness (or, for biologics, evidence that the product is “safe, pure, and potent”) based on adequate and well-controlled clinical investigations.³³ FDA may also approve generic versions of an approved drug product as well as biological products that are

biosimilar to a reference product.³⁴ Generic drug approval requires proof of bioequivalence, whereas a biosimilar must be highly similar to the reference product, with “no clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product”.³⁵ In 2020, FDA approved 53 new drugs and biological products, 72 first-time generic drugs, and three biosimilar products.³⁶

FDA’s timeline for reviewing NDAs and BLAs is generally set by a commitment letter issued by the Agency under the Prescription Drug User Fee Act of 1992 (“PDUFA”). Following criticism of the slow pace at which FDA approved new drugs during the HIV/AIDS crisis in the 1980s, Congress passed PDUFA in 1992 to authorize the collection of user fees from drug manufacturers in order to help fund FDA’s drug approval process.³⁷ Congress reauthorizes PDUFA every five years, most recently in 2017, and parallel user fee programs now exist for generic drugs (“GDUFA”) and biosimilars (“BsUFAs”). In 2019, 45% of FDA’s budget was paid for by user fees, with the remaining 55% provided by federal budget authorization.³⁸ Performance goals under PDUFA stipulate that FDA aims to review and act on 90% of standard NDA and BLA submissions within 10 months of either filing (for new molecular entity (“NME”) drug products and original BLAs) or receipt (for non-NME drug products).³⁹ Certain drug products may also be eligible for priority review, under which FDA aims to review and act on 90% of NDA and BLA submissions within six months of either filing or receipt.⁴⁰

An NDA or BLA can receive priority review if it is for a drug that treats a serious condition and, if approved, would provide a significant improvement in safety or effectiveness.⁴¹ In addition to priority review, other programs may be available to help expedite the development and review of drugs intended to address an unmet medical need in the treatment of serious or life-threatening diseases or conditions, including breakthrough therapy designation, fast track designation, and accelerated approval.⁴²

In addition to approving new drugs, FDA also grants exclusive marketing rights to drugs approved under certain criteria. New chemical entities, meaning drugs that contain no active moiety that has been approved by FDA, benefit from five years of marketing exclusivity, running from the time of NDA approval.⁴³ During that time, FDA cannot accept for review any NDA or abbreviated NDA (“ANDA”) or a drug containing the same active moiety.⁴⁴ FDA offers 12 years of exclusivity for biologics, seven years for orphan drugs (drugs designated and approved to treat diseases or conditions affecting fewer than 200,000 in the U.S., or more than 200,000 with no hope of recovering costs), three years for applications or supplements containing new clinical investigations, and six additional months of market protection where the sponsor has conducted and submitted pediatric studies.⁴⁵ Other incentives are also available, such as priority review vouchers for drugs treating neglected tropical diseases, rare pediatric diseases, and medical countermeasures.⁴⁶

Unlike regulators in many other countries, FDA does not consider price or cost-effectiveness in approving prescription drug products through the use of health technology assessment (“HTA”) bodies or otherwise regulate the prices charged by manufacturers or reimbursement offered by payers. As described in further detail below, however, both government and private payers view FDA approval as a precondition for reimbursement.

Coverage and reimbursement

Whether a drug product is covered, and at what price, is determined by each payer’s coverage, coding, and payment criteria. This section provides key terminology applicable to coverage and reimbursement,⁴⁷ followed by a summary of criteria for reimbursement under the two largest government-sponsored plans, Medicare and Medicaid, as well as the 340B Program. This section also includes considerations for coverage and reimbursement under private plans.

Key terminology

Actual Acquisition Cost (“AAC”). A state Medicaid program’s determination of a pharmacy’s actual price paid to acquire a drug product marketed or sold by a manufacturer.⁴⁸

Average Manufacturer Price (“AMP”). The average price paid to the manufacturer for a drug in the U.S. by (1) wholesalers for drugs distributed to retail community pharmacies, and (2) retail community pharmacies that purchase the drug directly from the manufacturer.⁴⁹

Average Sales Price (“ASP”). The average price of a manufacturer’s sales of a drug (by National Drug Code) to all purchasers in the U.S., as calculated by sales divided by the total units of the drug sold by the manufacturer in the same quarter.⁵⁰

Average Wholesale Price (“AWP”). The list price of a drug from a wholesaler to a pharmacy, as calculated and published by certain price reporting compendia.⁵¹

Best Price. The lowest available price offered by the manufacturer to any wholesaler, retailer, or provider, excluding certain government programs.⁵²

Wholesale Acquisition Cost (“WAC”). The list price of a drug from a manufacturer to wholesalers or direct purchasers, not including prompt pay or other discounts, rebates or reductions in price.⁵³

Government-sponsored plans and programs

A. Medicare

Medicare was established in 1965 under Title XVIII of the Social Security Act as a federally funded program to provide health insurance to individuals aged 65 and older.⁵⁴ It has since been expanded to cover individuals with disabilities or end-stage renal disease (“ESRD”). CMS administers the Medicare program, along with Medicaid and certain other federal health care programs.

i. Benefit designs

Medicare benefits are defined by statute, and Medicare provides coverage only for an item or service that falls within the statutorily identified benefit categories. In addition, the Medicare statute expressly excludes from coverage certain items or services, such as cosmetic surgery and some dental services. For a drug product to be covered by Medicare, it must, among other things, be “reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member”.⁵⁵ The Medicare program is divided into four parts that offer different benefits for beneficiaries:

- Part A provides hospital insurance that covers inpatient hospital services, as well as post-hospital skilled nursing facility services, hospice care, and some home health services. Inpatient hospital services include drug products and biologics.⁵⁶ Individuals aged 65 and older generally qualify for premium-free Part A benefits based on payroll taxes they or their spouses paid. Individuals under age 65 who have received disability benefits for at least 24 months also qualify for premium-free Part A benefits. Part A benefits are managed by Medicare Administrative Contractors (“MACs”), which are private health care insurers awarded geographic jurisdictions to process certain Medicare claims.⁵⁷ MACs make coverage determination on a case-by-case basis or as local coverage determinations (“LCDs”) or pursuant to national coverage determinations (“NCDs”).⁵⁸
- Part B provides supplemental medical insurance for a range of outpatient services, including physicians’ services, laboratory services, durable medical equipment (“DME”), and other medical services.⁵⁹ Part B also provides coverage of certain items and supplies, such as outpatient drug products that are not usually self-

administered and are furnished incident to a physician's services.⁶⁰ All individuals entitled to Part A may voluntarily enroll and obtain Part B benefits for a monthly premium.⁶¹ Like Part A benefits, Part B benefits are managed by MACs, which determine coverage on a case-by-case basis or based on LCDs or pursuant to NCDs.⁶² Parts A and B, together, constitute "original Medicare".⁶³

- Part C Medicare Advantage ("MA"), formerly known as Medicare +Choice, provides an alternative method for beneficiaries to receive benefits. Instead of receiving benefits separately through Part A and Part B, beneficiaries may choose to enroll in a MA plan offering combined Part A and Part B benefits.⁶⁴ MA plans are administered by private health plans, such as health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), private fee-for-service ("PFFS") plans, and special needs plans ("SNPs"). These private plans contract with CMS to provide all the required Part A and B benefits through a managed care system.⁶⁵ Plans may also offer alternative cost-sharing arrangements for beneficiaries or coverage for additional benefits not covered under original Medicare, such as over-the-counter ("OTC") drugs, vision care, or dental services.⁶⁶ All MA plans, except PFFS plans, must offer options that include coverage for prescription drugs ("MA-PDs").⁶⁷ MA-PDs generally must comply with Part D requirements, as discussed below.
 - Part D was established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA") and first implemented in 2006. Part D offers voluntary prescription drug coverage for beneficiaries entitled to Part A benefits or enrolled in Part B. Beneficiaries with original Medicare can enroll in a stand-alone prescription drug plan ("PDP") that is administered by a private health plan.⁶⁸ Part D plan sponsors create formularies identifying the prescription drugs that are covered by their plans. Formularies must meet federally specified criteria, including coverage of all therapeutic categories and classes and providing at least two drugs in each category or class.⁶⁹ Part D plans must be reviewed and approved by CMS.⁷⁰
- ii. Coverage and reimbursement methodology

As a preliminary matter, drug products generally must be approved by FDA in order to be reimbursed by Medicare. Parts A and B, however, cover only items or services that are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member".⁷¹ Thus, drug products also must be considered "reasonable and necessary" based on available clinical and scientific evidence, which is a different standard from FDA approval. In addition, Part D covers only outpatient prescription drug products that are FDA-approved and used for a medically accepted indication.⁷²

As indicated above, coverage determinations for drug products vary depending on which Part of Medicare is reimbursing. With respect to Medicare Parts A and B, most coverage determinations are made by MACs on a case-by-case basis or through LCDs to determine whether a given product will be covered in the MAC's jurisdiction. CMS also makes NCDs to determine coverage of a drug product nationwide.⁷³ MACs typically review new drug products upon submission of an LCD request, which triggers a 60-day review period to determine whether the request is complete, and then a lengthier review to evaluate the request itself, invite and incorporate public comment, and ultimately issue a final determination.⁷⁴

Under Part D, the private plan sponsors administering the PDP and MA-PD benefits determine which prescription drug products are covered. The plan sponsors

developing formularies to identify which prescription drug products are covered, subject to the requirements above. Formularies usually include “tiers” setting forth different beneficiary cost-sharing requirements.⁷⁵ Part D formularies must be developed and reviewed by a pharmacy and therapeutics (“P&T”) committee, which must “make a reasonable effort” to review new drug products within 90 days and make coverage determinations within 180 days of a drug’s introduction to the market.⁷⁶ CMS reviews formularies to ensure that they are consistent with federal requirements related to formulary design. A plan must cover at least two drugs for a particular therapeutic class,⁷⁷ and must cover “substantially all” immunosuppressant (for prophylaxis of organ transplant rejection), antidepressants, antipsychotics, anticonvulsants, antiretrovirals, and antineoplastics.⁷⁸

Part A reimbursement

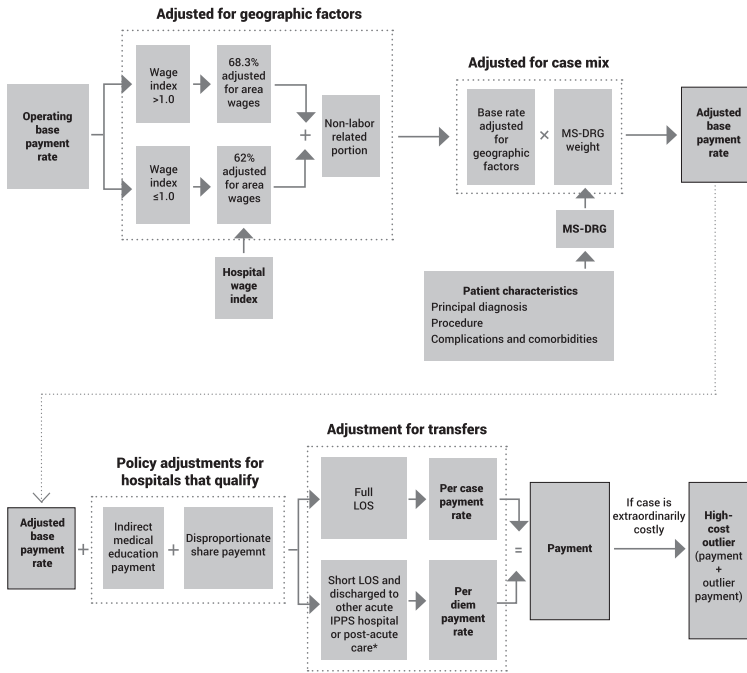
Reimbursement for most acute care hospital services under Part A is determined using the inpatient prospective payment system (“IPPS”) based on diagnosis-related groups (“DRGs”). The IPPS was established by Congress through the Social Security Amendments of 1983.⁷⁹ Reimbursement under Part A is intended to cover all of the services and supplies provided during the beneficiary’s spell of illness, including any drug products provided to the beneficiary; hospitals are statutorily prohibited from billing for items and services separately, or “unbundling” items and services.⁸⁰

The IPPS formula contains two basic components. First, a base payment amount is prospectively determined by CMS to cover the operating and capital expenses per discharge, adjusted by a wage index for the geographic area in which the hospital is located.⁸¹ Second, a weighting factor is associated with the DRG to which the beneficiary is assigned, to account for the resources required to treat the beneficiary.⁸² The base payment amount, adjusted by the wage index, is multiplied by the weight of the beneficiary’s DRG to determine the reimbursement payment amount. Medicare may also provide add-on payments, on top of the adjusted base payment, to cover costs associated with extraordinary treatment cases (“outliers”), teaching hospitals, or qualified new technologies. Disproportionate share hospitals (“DSHs”) that treat a certain volume of low-income patients receive additional payments for operating and capital expenses.⁸³ Additionally, Medicare has established several quality incentive programs under which hospitals may receive incentive payments or penalties associated with quality of care criteria set by CMS.⁸⁴

Certain hospitals, or hospital units, are exempted from the IPPS and receive reimbursement based on alternative methodologies. These include psychiatric hospitals or units, rehabilitation hospitals or units, children’s hospitals, and long-term care hospitals.⁸⁵

See overleaf

Figure 6: Acute inpatient prospective payment system for Fiscal Year 2021⁸⁶



Note: MS–DRG (Medicare severity diagnosis related group), LOS (length of stay), IPPS (inpatient prospective payment system). Capital payments are determined by a similar system. In addition to the inpatient operating and inpatient capital payments per discharge, hospitals may receive additional payments, such as those related to direct graduate medical education, uncompensated care, and bad debts. Additional payments are also made for certain rural hospitals. Hospitals may receive penalties or additional payments based on their performance on quality standards.

** Transfer policy for cases discharged to post-acute care settings applies for cases in 278 selected MS–DRGs.*

Part B reimbursement

Medicare reimburses certain drug products under Part B when they are administered “incident to” a physician’s services, generally in the physician’s office or other outpatient setting.⁸⁷ Part B drugs include, for example, drugs that are infused or injected. These drugs are reimbursed under the “buy and bill” model, through which providers first purchase drugs and then submit claims for reimbursement after the drugs have been administered to a beneficiary. In order to obtain reimbursement for Medicare Part B drugs, providers must submit claims to MACs using Healthcare Common Procedure Coding Systems (“HCPCS”) codes.⁸⁸

The current reimbursement methodology for most Part B drugs was established by the MMA.⁸⁹ Under this methodology, reimbursement payments for Part B drugs are generally calculated based on the ASP, which the manufacturer reports to CMS.⁹⁰ A drug’s ASP is calculated by dividing the manufacturer’s sales of the drug to all purchasers in the U.S. in a specific quarter (excluding nominal sales to certain entities and sales that are exempt from the determination of Medicaid best price) by the number of units of the drug sold by the manufacturer in the same quarter.⁹¹

Manufacturers report ASP on a quarterly basis. Certain manufacturers, such as those with Medicaid rebate agreements, are obligated to report ASP data,⁹² while other manufacturers voluntarily report ASP data or WAC data.⁹³ Reimbursement rates are updated quarterly; however, the rates are calculated using the reported ASP from two quarters ago.⁹⁴

Reimbursement for Part B drugs administered in the physician office setting is statutorily set at 106% of ASP, referred to as “ASP+6”.⁹⁵ Beneficiaries are generally responsible for 20% of the cost of drug products under Part B.⁹⁶ ASP+6 is intended to account for variability in provider acquisition costs and to compensate providers for the additional costs associated with the complexity of Part B drugs, many of which are used to treat serious illnesses such as cancer, cerebral palsy, and multiple sclerosis. Specific Part B drugs, including newly launched drugs, certain preventative vaccines, compounded drugs, and certain radiopharmaceuticals, are reimbursed under alternative formulas, rather than at ASP+6.⁹⁷

Under certain circumstances, reimbursement for Part B drugs is included, or “bundled”, with the payment for other services. For example, payments for certain drugs administered in hospital outpatient departments are bundled with the payments for services under the hospital outpatient prospective payment system (“OPPS”).⁹⁸ Other drug products, such as drugs with pass-through status, are reimbursed separately under OPPS. Reimbursement rates for such drugs vary from year to year and are currently set at ASP+6 for most drugs and ASP minus 22.5% for most drugs acquired through the federal 340B program, discussed below.⁹⁹

Part C reimbursement

MA plans contract with CMS to provide all required Part A and Part B items and services to Medicare beneficiaries in exchange for a monthly capitated payment. MA contracts are awarded based on a competitive bidding process. Reimbursement payments are then calculated by comparing the plan’s bid, which establishes the plan’s estimated costs of providing Part A and Part B services to the average beneficiary, to the benchmark plan. If the plan’s bid is lower than the benchmark, the reimbursement payment equals the bid amount, plus a rebate based on the difference between the bid and the benchmark that is passed on to the beneficiaries. However, if the bid is equal to or greater than the benchmark, the benchmark will be the reimbursement payment and beneficiaries are required to pay an additional premium based on the difference between the bid and the benchmark.¹⁰⁰

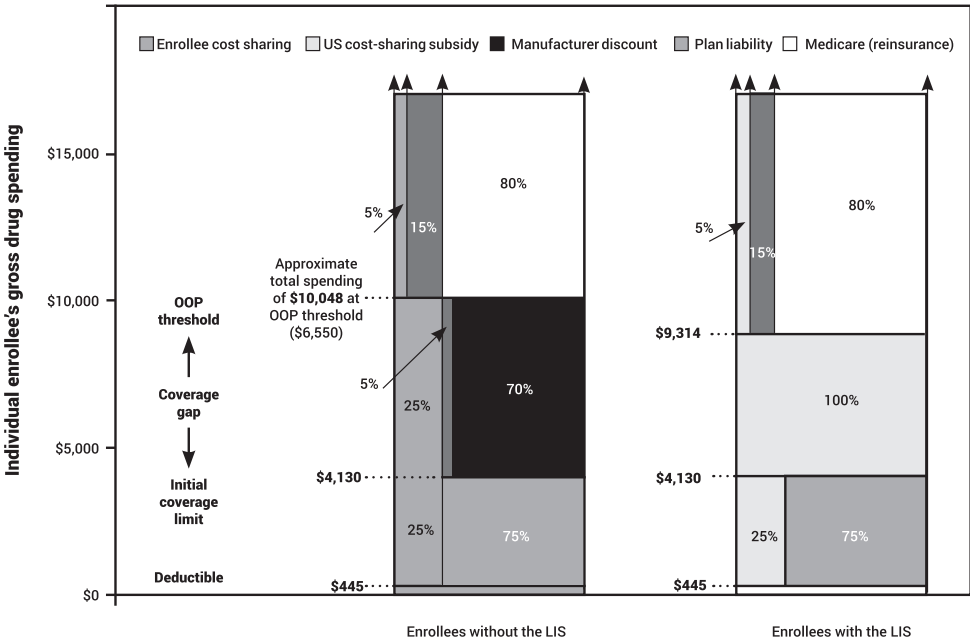
For MA-PD plans offering prescription drug coverage, a separate Part D bid must be submitted to CMS. Reimbursement for the prescription drug part of the MA plan is then calculated separately, in the same manner as stand-alone PDPs (discussed below).¹⁰¹

Part D reimbursement

Under Part D, stand-alone PDPs must provide standard prescription drug coverage, as set forth by statute, or alternative coverage that provides actuarially equivalent benefits.¹⁰² In 2021, the standard benefit includes a \$445 deductible and 25% coinsurance for the cost for both brand-name and generic drug products between \$455 and \$4,130. Beneficiaries then enter the coverage gap, also referred to as the “doughnut hole”, until they reach the catastrophic limit and out-of-pocket threshold of \$6,550. After reaching the catastrophic limit, beneficiaries pay the higher of either a 5% coinsurance or a set amount per prescription.¹⁰³ Under Part D as it was originally implemented in 2006, beneficiaries were responsible for all drug costs incurred while they were in the coverage gap. However, provisions of the Patient Protection and Affordable Care Act (often shortened to the Affordable Care Act or “ACA”) slowly reduced cost-sharing requirements during the doughnut hole, including by phasing in larger Medicare subsidies and requiring manufacturers to provide discounts for brand-name during purchased by beneficiaries in the coverage gap.¹⁰⁴ As of 2020, the doughnut hole is closed, meaning beneficiaries are responsible for only the 25% coinsurance until they reach the catastrophic limit.¹⁰⁵ Different

cost-sharing obligations apply for qualifying beneficiaries who receive low-income subsidies (“LIS”) under Part D, for which the federal government pays in full or in part the drug cost-sharing expenses.¹⁰⁶ Full LIS beneficiaries have a \$0 deductible and subsidized coinsurance payments in the initial coverage (25%), coverage gap (25%), and catastrophic coverage (5%) phases, with a copayment of \$9.85; partial LIS beneficiaries have a \$99 deductible plus a coinsurance of 15% through the coverage gap phase and a \$9.85 copayment in the catastrophic coverage phase.¹⁰⁷

Figure 7: Part D 2021 standard defined benefit and LIS benefit structures¹⁰⁸



Note: LIS (low-income subsidy), OOP (out of pocket). For beneficiaries without the LIS (left bar), the coverage gap is depicted as it would apply to brand-name drugs, which are eligible for a 70% manufacturer’s discount in the coverage gap. There is no discount for generic prescriptions, and thus cost sharing in the coverage gap is 25% and plans are responsible for 75%. Because of this difference, total covered drug spending at the out-of-pocket (“OOP”) threshold depends on the mix of brand and generic prescriptions each individual fills while in the coverage gap. The dollar amount shown (\$10,048) was estimated by CMS for an individual with an average mix of drugs who does not receive Part D’s LIS and has no other supplemental coverage. The bar depicting LIS enrollees (right) reflects full rather than partial LIS coverage. LIS enrollees do not receive brand discounts from manufacturers. For most LIS enrollees, Medicare’s LIS pays for all cost sharing except nominal copayments, thereby including most spending in the coverage gap.

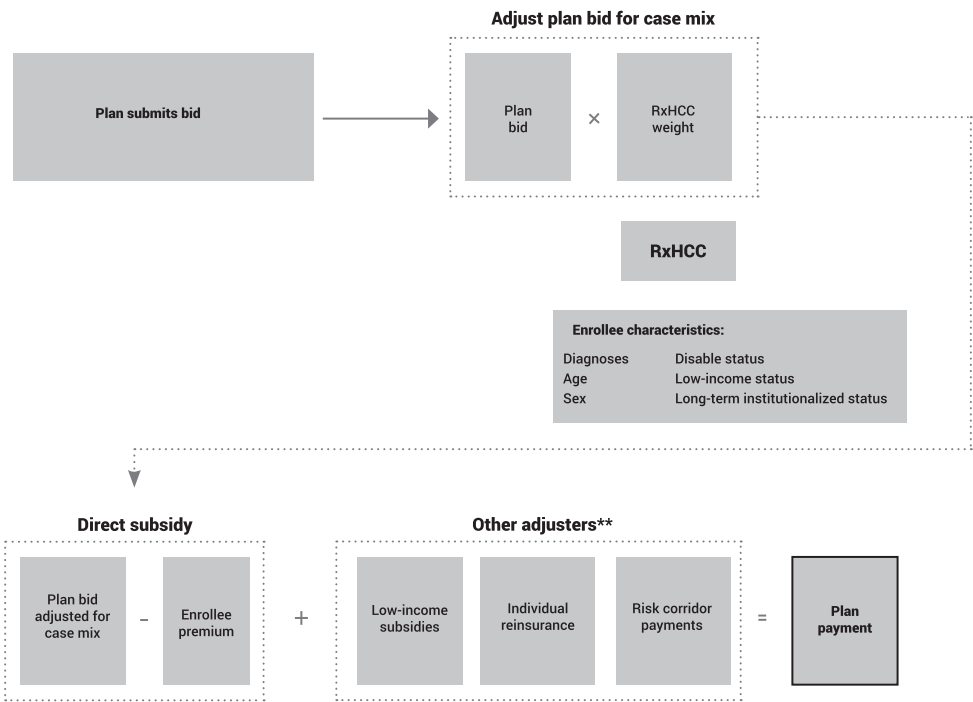
Source: MedPAC depiction of Part D benefit structure for 2021 as set by law.

Part D reimbursement payments made to PDPs and MA-PDs are based on a competitive bidding process. Plan sponsors determine their bids based on the expected costs of providing coverage for the average Medicare beneficiary. CMS provides monthly capitated payments to

plans to subsidize the standard benefit coverage.¹⁰⁹ As noted above, CMS also pays additional subsidies for LIS beneficiaries and reinsurance subsidies to cover the costs of beneficiaries with high prescription drug expenses.

Unlike reimbursement under Medicare Part A and Part B, the federal government does not play a role in determining the calculation for drug product reimbursement under Part D. Instead, plan sponsors usually contract with PBMs to negotiate prices with manufacturers. Plans also establish a network of pharmacies to provide access to covered drug products for its beneficiaries.¹¹⁰ The Medicare statute prohibits the federal government from interfering with Part D price negotiations or establishing a required formulary or reimbursement formula for Part D drug products.¹¹¹

Figure 8: Part D payment system¹¹²



Note: RxHCC (prescription drug hierarchical condition category). The RxHCC is the model that estimates the enrollee risk adjuster. Beginning in 2011, CMS replaced its single model of risk scores with five separate sets of model coefficients for: long-term institutionalized enrollees; aged low-income enrollees; aged non-low-income enrollees; disabled low-income enrollees; and disabled non-low-income enrollees. Prior to 2011, payments on behalf of beneficiaries with low-income and long-term institutionalized status were adjusted using multipliers intended to reflect those individuals’ higher levels of drug spending.

* Figure 8 outlines the process for calculating enrollee premiums.

** Plans receive interim prospective payments for individuals’ reinsurance and low-income subsidies that are later reconciled with CMS.

B. Medicaid

Medicaid was established by the Social Security Act of 1965 to provide health care services to low-income individuals.¹¹³ The program is funded jointly by federal and state governments. States are not required to participate in Medicaid, but all 50 states, Washington, D.C., and the U.S. territories have chosen to participate. The federal Medicaid statute establishes federal requirements that states must satisfy in order to receive matching federal funds. However, the statute also provides flexibility for states to design their programs within the federal guidelines.¹¹⁴

In order to receive Medicaid benefits, individuals must qualify through an eligibility pathway that provides coverage to identified populations. Some pathways are mandated by federal law, while others are optional pathways that states may choose to offer. States may also apply for a Medicaid waiver in order to offer coverage to populations beyond the mandatory and optional pathways. The federal Medicaid statute defines the categories of individuals who are covered by a certain pathway (“categorical eligibility”) and whether there are any financial requirements (“financial eligibility”), as well as the extent to which a state can alter or adjust the pathway’s requirements.¹¹⁵

i. Benefit designs

Medicaid coverage includes a range of benefit options, including primary care, preventative care, and long-term care services and support. Medicaid beneficiaries may receive benefits through a fee-for-service (“FFS”) system or a managed care system, depending on which systems are offered by the state. Through the FFS system, states provide reimbursement to health care providers for each service they provide to beneficiaries. Through the managed care system, states pay managed care organizations (“MCOs”) a monthly capitated fee to provide benefits to eligible individuals.¹¹⁶

An individual’s benefits vary based on the eligibility pathway through which he or she obtains coverage. State programs may offer either traditional Medicaid benefits, which include a range of required and optional benefits specified by federal law, or alternative benefit plans (“ABPs”), which are based on a coverage benchmark but must include the essential health benefits (“EHBs”) that private health plans are generally required to provide. States may also apply for a Medicaid waiver to provide additional services.¹¹⁷ Under the traditional Medicaid benefit framework, prescription drug coverage is an optional benefit, but all states have chosen to offer it; for ABPs, prescription drug coverage is a mandatory benefit.¹¹⁸ Further, some state Medicaid programs also provide coverage for OTC drug products.¹¹⁹

Individuals who are eligible for both full Medicaid benefits and Medicare, known as “dual eligibles”, generally must obtain prescription drug coverage through a Medicare Part D plan. State Medicaid agencies are statutorily prohibited from providing reimbursement for drug products covered by Part D for dual eligibles, but agencies may provide reimbursement for drug products that are expressly excluded from the definition of a covered Part D drug.¹²⁰

ii. Coverage and reimbursement methodology

Pursuant to the Medicaid Drug Rebate Program (“MDRP”),¹²¹ state Medicaid programs must maintain an “open formulary” covering all drugs by a participating manufacturer. In exchange, manufacturers agree to make rebate payments intended to ensure that Medicaid pays the “best price” for drug products.¹²² Many states also have developed preferred drug lists (“PDLs”), which include drugs for which manufacturers offer supplemental rebates beyond those offered by the MDRP. Providers are encouraged to prescribe drugs on the state PDL to Medicaid

beneficiaries; the drugs on the PDL are generally subject to fewer utilization management controls. Additionally, the federal Medicaid statute allows state programs to exclude certain drugs, classes of drugs, or drug uses from coverage.¹²³

State Medicaid programs usually reimburse community retail pharmacies for drug products dispensed to Medicaid beneficiaries. In addition, some states may require Medicaid beneficiaries to pay a nominal copayment for outpatient prescription drug products.¹²⁴

FFS Medicaid reimbursement payments to pharmacies are generally based on the drug product's ingredient cost and the pharmacist's dispensing fee. In 2016, CMS issued a final rule requiring states to use the AAC to determine ingredient cost.¹²⁵ However, federal regulations permit states to choose how they calculate AAC by using either a survey of pharmacy providers, the AMP, or the National Average Drug Acquisition Cost ("NADAC").¹²⁶ The drug's ingredient cost is combined with a professional dispensing fee, which is usually a fixed amount intended to cover the pharmacy's costs for obtaining, storing, and dispensing the drug.¹²⁷

Medicaid managed care plans also reimburse pharmacies for drug products dispensed to beneficiaries. Like payments made by FFS Medicaid, managed care reimbursement rates are based on the drug's ingredient costs and dispensing fees. To calculate ingredient costs, MCOs are not required to use the AAC but must make payments sufficient to ensure appropriate access for their beneficiaries.¹²⁸ MCOs negotiate reimbursement terms with pharmacies rather than creating a generally applicable payment formula. They also may negotiate their own rebates and other discounts from manufacturers.¹²⁹

Many states contract with PBMs, which serve as intermediaries between the state Medicaid agencies, pharmacies, manufacturers, and beneficiaries. States may use PBMs for Medicaid programs administered on a FFS basis or through a managed care system to perform multiple administrative and financial functions. PBMs working on behalf of MCOs may negotiate drug prices with pharmacies; conversely, PBMs working with Medicaid programs must comply with federal and state requirements for drug reimbursement.¹³⁰ Concerns regarding the lack of transparency for PBMs have led some states to consider disclosure requirements for PBMs.¹³¹

To control the cost of prescription drugs, federal and state governments have implemented policies to create certain payment limitations for Medicaid reimbursements. The federal upper limit ("FUL") is a payment limitation that caps the reimbursement payment for ingredient costs of certain multiple source drugs.¹³² Currently, CMS has set the FUL at 175% of the weighted average of the most recently reported AMP for the specific form and strength of a drug.¹³³ In addition, most states have created a maximum allowable cost ("MAC") program to limit reimbursements for certain multiple source drugs. State MAC programs operate similarly to the FUL cap; however, states have discretion to decide which drugs are included in the program and how the reimbursement limitation for those drugs is calculated. As of 2014, 45 states had established MAC programs.¹³⁴ Finally, for single source drugs and drugs not subject to FUL or MAC limitations, reimbursement – in the aggregate – may be determined by the lower of either (1) the AAC and dispensing fee, or (2) the providers' usual and customary charges to the general public.¹³⁵

Pursuant to the MDRP, as discussed above, a drug product is covered by Medicaid only if the manufacturer enters into a Medicaid rebate agreement.¹³⁶ The agreement

requires the manufacturer to provide a rebate to the state’s Medicaid agency, which is then shared between the federal and state governments in order to reduce federal and state expenditures. For single source and innovator multiple source drugs, Medicaid’s basic rebate formula requires a payment in the amount of the greater of either the difference between a drug’s quarterly AMP and the best price for the same period, or a flat percentage (23.1%) of the drug’s quarterly AMP.¹³⁷ Drug manufacturers owe an additional rebate when their AMPs for individual products increased faster than inflation. For other drug products, separate rebate structures would apply, as demonstrated in Figure 9.

Figure 9: Medicaid drug rebate formulas¹³⁸

Drug Category	Basic Rebate	Additional Rebate
Single Source	The greater of either 23.1% of AMPa per unit or AMP minus best price per unit	Required when prices rise faster than the inflation rates – difference between the products’ per unit current AMP and the base period AMP adjusted by CPI-Uc for each quarter since launch
Innovator Multiple Source Drugs	The greater of either 23.1% of AMP or AMP minus best price per unit	Required when prices rise faster than the inflation rates – difference between the products’ per unit current AMP and the base period AMP adjusted by CPI-U for each quarter since launch
Line Extension Productsd	The greater of (1) the basic and additional rebate for the new drug, or (2) the product of the line extension drug’s AMP and the highest additional rebate for any strength of the original brand drug and the number of units of each dosage form and strength of the line extension drug	
Blood Clotting Factorse	The greater of 17.1% of AMP per unit or AMP minus best price per unit	Required when prices rise faster than the inflation rates – difference between the products’ per unit current AMP and the base period AMP adjusted by CPI-U for each quarter since launch
FDA Approved Pediatric Indicationf	The greater of 17.1% of AMP per unit or AMP minus best price per unit	Required when prices rise faster than the inflation rates – difference between the products’ per unit current AMP and the base period AMP adjusted by CPI-U for each quarter since launch
Non-innovator Multiple Source and Other Drugs	13% of AMP	Not applicable

Source: Congressional Research Service (“CRS”) review of the SSA §1927. Payment for Covered Outpatient Drugs, and 42 CFR §447.502. Definitions.

- a. AMP is the average manufacturer price, or the average U.S. price manufacturers received for their product when sold to retail community pharmacies.
- b. Best price (single source and innovator multiple source) is the drug manufacturer’s lowest U.S. price during the reporting period (see the glossary in Appendix E).
- c. CPI-U is the consumer price index for all urban consumers as updated by the U.S. Department of Labor (<http://www.bls.gov/cpi/>).
- d. A line extension is an oral solid dose (generally a pill or capsule) of a single source or multiple source innovator drug that is a new formulation of an existing drug, such as an extended release formulation (SSA §1927(c)(2)(C). CMS proposes to use the FDA regulation 21 CFR §206.3, which is defined solid oral dosage form as capsules, tablets, or similar drug products intended for oral use (77 Federal Register 5324, February 2, 2012).
- e. Clotting factor drugs receive a separate payment under SSA §1842(o)(5) and are

included on a regularly updated list maintained by the Secretary (SSA §1927(c)(1)(B)(iii)(II)(aa)).

- f. FDA approved pediatric drugs are those approved for marketing by the FDA for pediatric indications (SSA §1927(c)(1)(B)(iii)(II)(bb)).*

C. 340B drug pricing program

The federal 340B program requires manufacturers to provide outpatient prescription drugs to certain providers that serve low-income and uninsured individuals (frequently referred to as “safety net providers”).¹³⁹ Established in 1992, the 340B program was conceived to address an unintended consequence of the MDRP – the requirement to report the best price resulted in manufacturers no longer offering voluntary discounts to safety net providers.¹⁴⁰ Under the 340B program, any manufacturer that participates in the MDRP must: (1) offer the 340B price if the drug is made available to any other purchaser at any price; (2) offer to covered entities (defined by Section 340B of the Public Health Service Act to include federally qualified health centers, various disease-specific programs, and publicly owned hospitals treating a disproportionate number of low-income patients); (3) cover outpatient drugs (defined by statute to include all outpatient drugs, including infusion therapies, provided they are not associated with an inpatient stay); and (4) set the 340B price at no more than a statutorily defined ceiling (the “ceiling price”).¹⁴¹

The ceiling price is calculated quarterly using MDRP figures (AMP minus the Unit Rebate Amount (“URA”)) from two quarters prior, except that 340B pricing is estimated for new drugs until the MDRP figures become available. Manufacturers may voluntarily offer lower “sub-ceiling” pricing to covered entities. After purchasing the drug at the ceiling price, the covered entity generally seeks reimbursement from the patient’s insurance (commercial or government) or potentially the patient. The statute prohibits covered entities from obtaining duplicate discounts under 340B and MDRP, and bans them from diverting discounted drugs to anyone but their own patients. The mandatory discounts required under the 340B Program are exempt from best price (and related) calculations. Consequently, critiques of the program include that discounts are sometimes not passed onto the uninsured or underinsured patients and covered entities do not use the proceeds from the difference between the 340B price and the reimbursed amount to provide charity care.¹⁴²

In 2010, the ACA expanded 340B eligibility to include additional categories of hospitals, and draft guidance from the Health Resources and Services Administration (“HRSA”) removed the restriction on 340B entities’ use of only one contract pharmacy, leading to growth in the number of 340B prescriptions.¹⁴³ In addition, hospital acquisition of oncology practices has driven increased 340B profitability for hospitals.¹⁴⁴ 340B spending has increased significantly in recent years, rising from \$5.3 billion in 2010 to \$24.3 billion in 2018.¹⁴⁵

In 2018, HHS reduced Medicare Part B reimbursement rates for certain drugs acquired under the 340B program from ASP+6 to ASP minus 22.5%, so as to “better, and more appropriately, reflect the resources and acquisition costs that these hospitals incur.”¹⁴⁶ In litigation challenging this change in reimbursement, a U.S. District Court ruled that HHS exceeded its statutory authority by reducing the reimbursement rate in this manner.¹⁴⁷ In 2020, a U.S. Court of Appeals reversed the district court’s decision and determined that HHS had reasonably interpreted the Medicare statute and acted within its authority in implementing the rate cut of ASP minus 22.5% for drugs purchased under the 340B program.¹⁴⁸ In February 2021, the American Hospital Association (“AHA”), the Association of American Medical Colleges (“AAMC”), and America’s Essential Hospitals (“AEH”) asked the U.S. Supreme Court to review the case. The petition for review is still pending as of June 2021.¹⁴⁹

In 2020, several manufacturers sought to prevent duplicate discounts and ineligible rebates in the 340B Program by limiting distribution of 340B covered outpatient drugs via contract pharmacies. The 340B statute does not reference contract pharmacies; however, HRSA guidance in 2010 suggested that covered entities may create ship-to arrangements with an unlimited number of contract pharmacies.¹⁵⁰ In response to the manufacturers' limited distribution approach, HRSA sent individual manufacturers letters stating that their new contract pharmacy policies violate the 340B statute and that any overcharges must be refunded to impacted entities.¹⁵¹

D. Private plans

Over two-thirds of Americans are covered by private insurance. The vast majority of those with private insurance have employment-based coverage – in 2018, 178.4 million Americans had coverage through an employer.¹⁵² The ACA requires large employers to provide full-time employees and their dependents with coverage, and plans must meet minimum standards for affordability and coverage.¹⁵³ Employers generally pay most of the insurance premium on behalf of employees and their dependents, while employees are responsible for the remainder of the premium and cost-sharing requirements. On average, employers pay 82% of the premium for single coverage and 71% for family coverage.¹⁵⁴ Americans can also purchase insurance directly through state-based and multi-state Affordable Health Insurance Exchanges (also known as “Health Insurance Marketplaces”), where subsidies are available to individuals with incomes between 100% and 400% of the federal poverty level (“FPL”).¹⁵⁵ Additionally, individual and group plans are also available for purchase outside of the Health Insurance Marketplaces.¹⁵⁶

Private plans typically include medical and pharmacy benefits. Drugs used with durable medical equipment (“DME”) are often covered under the pharmacy benefit. Physician-administered drugs, regardless of formulation, are typically covered and paid under the medical benefit. FDA approval is typically a prerequisite for coverage, but private plans have greater flexibility than public plans in defining the benefit category and placement of drugs on formularies, as well as adopting utilization controls, as discussed below.

Medicare rates frequently serve as a floor for payments under private plans. However, unlike Medicare's Part A and B benefits, private payers can and do negotiate prices and payments, often through negotiated aggregate rebates with drug manufacturers facilitated by PBMs. Drug payment rates vary depending on contracts with providers, manufacturers, vendors, and employers. Private payers often consider cost or cost-effectiveness in the coverage process, with many utilizing complex formularies to determine patient cost-sharing responsibilities, as discussed below.

Additional issues that affect pricing and reimbursement

Other parties in the drug supply chain

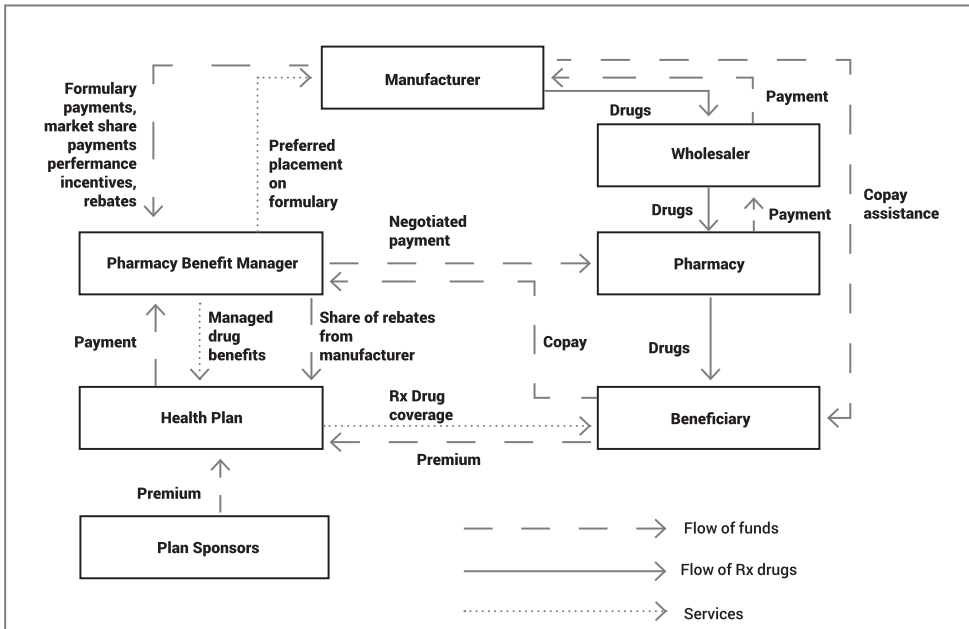
Understanding the pharmaceutical supply chain is key to understanding the cost of prescription drugs in the U.S., particularly in the private market. Manufacturers rarely receive the WAC or list price set by manufacturers because products are frequently discounted throughout the distribution system and are subject to various forms of service fees. These discounts flow through wholesale distributors, pharmacies, payers, and PBMs and are often paid retrospectively by the manufacturer in the form of rebates.

Wholesale distributors buy drugs from manufacturers and distribute them to pharmacies, hospitals, and other medical facilities. Pharmacies negotiate with wholesalers to purchase prescription drugs for their inventory, and, in turn, wholesalers negotiate with manufacturers to obtain drugs to distribute to pharmacies and other purchasers. Wholesalers also facilitate charge-backs for manufacturers to effectuate negotiated prices for their customers.

PBMs represent payers and employers in the selection, purchase, and distribution of prescription drug benefits, and often serve as a broker, without fiduciary obligations, between individual employers, payers, drug manufacturers, and pharmacies.¹⁵⁷ PBMs play several roles throughout the supply chain. These include:

- **Developing and maintaining prescription drug formularies for insurance plans.** PBMs maintain a national formulary, as well as custom client formularies, to provide tiered coverage for branded and generic prescription drugs.
- **Negotiating discounts from manufacturers.** PBMs negotiate discounts from manufacturers on behalf of insurers, in exchange for preferred formulary placement. Discounts generally come in the form of rebates. PBMs retain these rebates and pass along some portion of the manufacturer price concession under a blended effective rate for an employer's or plan's branded drug spend. Rebate agreements between PBMs and manufacturers often contain price protection provisions that require the manufacturer to pay additional concessions to the payer or PBM in the form of a penalty if the list price of the product increases above a predefined threshold year over year, on a cumulative multi-year basis, or both. Some larger payers negotiate directly with manufacturers for rebates and use the PBM for other administrative services such as Drug Utilization Review ("DUR") and claims processing. Rebates are not passed down to plan beneficiaries, but they may help reduce beneficiaries' overall insurance premium costs. Of note, rebates paid to PBMs have come under criticism as a key driver of drug costs¹⁵⁸ and have been the subject of recent rulemaking. Specifically, on November 20, 2020, the HHS Office of Inspector General ("OIG") promulgated a final rule amending the AKS safe harbor for discounts to eliminate protections for rebates or other price reductions from manufacturers to plan sponsors under Medicare Part D or PBMs acting on their behalf (commonly referred to as the "rebate rule"); the regulations simultaneously establish two new safe harbors that protect discounts offered by manufacturers on prescription drugs at the point-of-sale, allowing for a portion of the rebate to be passed through to the patient, and fixed-fee service arrangements between manufacturers and PBMs.¹⁵⁹ Implementation of the rebate rule has been delayed to January 2023, pursuant to litigation filed by the Pharmaceutical Care Management Association ("PCMA") against HHS.¹⁶⁰ It is unclear whether OIG will ultimately withdraw or modify the rebate rule prior to the January 2023 effective date. Additionally, the Federal Trade Commission ("FTC") continues to monitor PBM practices and impacts of PBM industry consolidation. FTC also recently established a working group to contemplate rulemaking, including competition rules with respect to rebates between manufacturers and third-party payers, such as PBMs.¹⁶¹
- **Creating pharmacy networks and negotiating lower dispensing fees.** PBMs create networks of pharmacies that agree to dispense prescription drugs under agreed-upon terms. PBMs negotiate a reimbursement rate for each drug product, as well as a dispensing fee. When a plan beneficiary pays for a prescription, the pharmacy generally passes the copayment or coinsurance to a PBM, which then pays the pharmacy the negotiated reimbursement and dispensing fee. This arrangement allows the PBM to create spread-pricing profits and impose penalty fees on pharmacies that do not achieve contracted performance goals such as rate of generic dispensing. PBMs also may operate pharmacies themselves, including mail-order and specialty pharmacies. When payers and PBMs operate and drive utilization to their own pharmacies through narrow networks, they can negotiate additional bulk purchase discounts from manufacturers that are retained by the payer or PBM pharmacy.

Figure 10: The flow of funds in the pharmaceutical distribution system¹⁶²



Various entities across the drug supply chain are increasingly contracting and consolidating both horizontally and vertically. For example, three PBMs – Express Scripts, CVS Caremark, and OptumRx – control the majority of the market, together totaling an estimated 71% of Medicaid and Medicare Part D beneficiaries and 86% of the private market.¹⁶³ This demonstrates a high level of horizontal consolidation in the PBM industry. Further, these PBMs have some form of common ownership with large retail chains and/or specialty pharmacies, as well as payers, demonstrating an increasing level of vertical integration: CVS Caremark is affiliated with CVS and Aetna; Express Scripts is affiliated with Accredo and Cigna; and OptumRx is affiliated with BrivoRx and UnitedHealthcare.

While PBMs generally consider vertical integration to be to the benefit of patients,¹⁶⁴ there are concerns that extensive consolidation has reduced transparency in the financial relationships among payers and other participants in the drug supply chain and may adversely impact patient access due to significant bargaining power of the consolidated entities. On the other hand, PBMs generally have demonstrated success in keeping payers’ net prices low and increasing the overall rate of price concessions achieved from manufacturers, providing a benefit to plans and payers. For example, a survey by the Pew Charitable Trust found that 91% of rebates were passed through to plans in 2016 (up from 78% in 2012).¹⁶⁵ PBMs retained roughly the same volume of rebates despite the higher rates of rebate pass-through due to an overall growth in rebate volume, including an estimated increase of manufacturer rebates from \$39.7 billion in 2012 to \$89.5 billion in 2016,¹⁶⁶ reflecting in part the impact of PBM bargaining power and negotiations.

Efforts to manage costs

Payers and PBMs have various tools at their disposal with which to control spending on prescription drugs. These tactics include:

- **Requiring greater cost sharing for high-cost products.** As indicated above, PBMs and payers have wide discretion to design formularies that determine how drugs are

reimbursed, as well as the rate of patient cost sharing for drug products (although, for Medicare Part D plans, these formulary designs must adhere to federal requirements and be approved by CMS). Tiered formularies are used to steer patients toward generics and branded drugs for which there exists no generic equivalent by requiring lower cost sharing for these drugs. Within a given formulary, tier 1 generally includes covered generic drugs (also called “preferred drugs”), and tier 2 generally includes preferred branded drugs for which there is no generic equivalent. Traditionally, PBMs used a three-tier structure, placing non-preferred drugs in tier 3. Today, many PBMs utilize a four-tier or five-tier structure, reserving the highest tiers (tiers 3, 4, or 5) for high-cost specialty drugs. PBMs shift a significant portion of the cost for non-preferred drugs to the patient, in the form of higher copayments (fixed dollar amounts) or co-insurance (a percentage of the cost of the drug). Negotiations with manufacturers typically involve the use of bidding tables where each manufacturer offers varying levels of rebates for exclusive, preferred, or parity formulary placement within competitive therapeutic classes (i.e., diabetes) where multiple clinically effective treatments are available for prescribing. Manufacturer bidding for government payer lives are typically separated from bidding activity for commercial payer lives due to the different coverage and reimbursement dynamics of each market. A developing trend is to show physicians the relative formulary status of a treatment option within their electronic health records at the time of prescribing, in order to better align the physician’s decisions with the lowest cost option for the patient, employer, or health system.¹⁶⁷

- **Utilization controls.** PBMs and insurance plans frequently require patients to obtain prior authorization before covering expensive medications. PBMs and insurance plans also may require a patient to try a preferred product (usually a lower cost generic) before agreeing to reimburse a more expensive product, a process known as “step therapy” or “fail first”. Additionally, plans and PBMs may block coverage of certain drugs altogether, or utilize narrow pharmacy networks to limit patient access.
- **Mandatory substitution of generics.** Most state Medicaid plans require pharmacies to dispense a generic version of a drug product, if available, unless the patient’s prescriber specifies that the branded version is medically necessary. Payers and PBMs also may encourage or require generic substitution, state law permitting. Multiple states require pharmacists to replace brand-name drugs with generics, unless a prescriber affirmatively blocks pharmacist substitution.¹⁶⁸ At least one state, Oklahoma, prohibits pharmacists from substituting pharmaceutical products without the consent of both the prescriber and the patient.¹⁶⁹
- **Cost-sharing/copayment accumulators and maximizers.** PBMs and insurance plans have increasingly utilized benefit designs such as accumulators and maximizers to minimize and/or capture the effect of drug manufacturer copayment assistance. Under accumulator programs, the plan does not allow the value of manufacturer copayment assistance to count toward the beneficiary’s deductible or out-of-pocket maximum. Thus, once the copayment assistance is exhausted, the beneficiary must pay the entire amount of his or her deductible before plan benefits are available. Under a maximizer program, the plan aligns the beneficiary’s copayment obligation with available copayment assistance from manufacturers (i.e., by dividing the annual maximum benefit to set monthly copayment amounts for beneficiaries). Manufacturer assistance applies to the beneficiary’s copayment obligation but not toward the beneficiary’s deductible or out-of-pocket maximum. Accumulator and maximizer programs are subject to ongoing policy activity.
 - Recent federal rulemaking clarifies that accumulator programs (and, by extension, any accumulator elements included in maximizer programs) are expressly permitted

for health plans sold on the Affordable Health Insurance Exchanges, as well as most other plans, to the extent permitted by state law.¹⁷⁰ Additionally, in December 2020, CMS revised the methodology for calculating AMP and best price as part of the Medicaid Value-Based Purchasing Final Rule to require, beginning in 2023, that manufacturers “ensure” the full value of the copayment assistance is passed on to the patient and is not subject to accumulator programs in order to exclude such assistance from AMP and best price calculations.¹⁷¹

- Certain states have proposed and/or enacted legislation to address copayment accumulators and maximizers. In 2019, Arizona, Illinois, Virginia, and West Virginia enacted provisions that effectively prohibit accumulator programs by requiring health care plans to apply any third-party payments, such as copayment assistance from manufacturers, toward a patient’s cost-sharing obligations.¹⁷² Between 2020 and 2021, over a dozen states enacted some form of cost-sharing or coupon legislation,¹⁷³ such as Virginia and West Virginia legislation requiring insurers to account for any payments made on an insured’s behalf in addition to the payments made by the insured when calculating the overall out-of-pocket cost sharing.¹⁷⁴ In 2021, Kentucky enacted legislation preventing insurers and PBMs from excluding any copayment assistance provided to beneficiaries when calculating cost-sharing requirements.¹⁷⁵ This is a rapidly evolving area with significant variation at both the state and federal policy levels.
- **Value-based contracts.** Manufacturers and payers are increasingly negotiating agreements to link the purchase price to clinical outcomes or financial measures, especially for high-cost specialty drugs. These arrangements are sometimes referred to as value-based contracts (“VBCs”), outcomes-based contracts (“OBCs”), or performance based risk sharing agreements (“PBRsAs”).¹⁷⁶ A number of legal and regulatory requirements may be implicated by these arrangements. For example, the federal AKS prohibits anyone from soliciting, receiving, offering, or paying any remuneration in return for a referral for an item or service that may be paid for by a federal health care program.¹⁷⁷ Statutory and regulatory safe harbors protect certain arrangements from AKS liability, including qualifying discount and warranty arrangements,¹⁷⁸ but there is some uncertainty with respect to how these safe harbors apply to VBC arrangements. In November 2020, HHS OIG issued a rule establishing three new safe harbors under the AKS for VBCs. However, these new safe harbor protections do not generally apply to manufacturers and other drug supply chain entities,¹⁷⁹ with a narrow exception for in-kind digital tools provided by manufacturers in care coordination. VBCs may also raise risks related to price reporting obligations, as the terms of such agreements can lead to significant variance in pricing at the per-patient level and potentially drop unit prices for certain patients below the “best price” traditionally offered for the drug product. In December 2020, CMS finalized regulations to facilitate value-based purchasing (“VBP”) arrangements by allowing manufacturers to report VBPs under one of two methodologies: (1) under a bundled sales approach, which has been traditionally employed by manufacturers to distribute any VBP discount proportionally to the total dollar value of all units sold as part of the bundled arrangement; or (2) under a “multiple best prices” approach, to report multiple best price points for a single dosage form and strength to reflect the discounts or prices available under the VBP.¹⁸⁰ VBCs may also raise issues related to off-label promotion; for instance, if there is a need to share data on potential outcomes that are helpful to identify value but are not otherwise included in product labeling. FDA guidance expressly permitting the communication of health care

economic information (“HCEI”) related to approved labeling lowers the risk related to such communications, and FDA has stated explicitly that it does not regulate terms for VBCs.¹⁸¹

- **Cost-effectiveness assessments.** PBMs and payers make coverage determinations based on certain cost-effectiveness information, including, where available, formal assessments conducted by the Institute for Clinical and Economic Review (“ICER”). ICER is a non-governmental entity that, similar to HTAs in other countries such as the National Institute for Health and Care Excellence (“NICE”), produces reports analyzing evidence on the effectiveness and value of drugs and other medical services in the U.S.¹⁸² ICER’s assessments evaluate two concepts: long-term value for money; and short-term affordability.¹⁸³ The assessments utilize the Quality-Adjusted-Life-Year (“QALY”) to compare incremental cost-effectiveness of care options, with a health-benefit price benchmark of \$100,000 to \$150,000 per additional QALY.¹⁸⁴ Notably, the ACA’s provisions for the Patient-Centered Outcomes Research Institute (“PCORI”) prohibit the use of QALYs as a means for cost-effectiveness assessments at the federal-level.¹⁸⁵ Although ICER cannot directly control coverage decisions, ICER has become increasingly important in payer and PBM coverage and utilization determinations. For example, CVS Caremark has initiated a program allowing clients to exclude drugs from coverage if they are launched at a price exceeding \$100,000 per QALY in analyses carried out by ICER.¹⁸⁶ Furthermore, certain states, such as New York, have relied on ICER reports to guide Medicaid drug review board decisions for certain covered outpatient drugs.¹⁸⁷ On a federal-level, the Department of Veteran’s Affairs (“VA”) has utilized ICER reports to help develop its drug formularies.¹⁸⁸ ICER has repeatedly received criticism for failing to include all evidence supporting clinical and economic benefits, lack of transparency in its assessments, and failing to incorporate enough of a patient-centered perspective, among other concerns.¹⁸⁹

Efforts to facilitate access

A. Manufacturer financial assistance

Manufacturers frequently provide financial assistance or free product to patients to facilitate access. Such assistance may include manufacturer-sponsored patient assistance programs (“PAPs”) (i.e. free drugs or diagnostic services), commercial copayment assistance (i.e. copayment coupons), and assistance provided by independent, third-party charitable entities (often referred to as “independent charity PAPs”). Eligibility for these types of programs may depend on income level, insurance status, and type of insurance. Additionally, manufacturers often provide other support services, such as assistance with navigating insurance coverage for specialty drugs.

Financial assistance to patients is highly regulated, particularly where this assistance is provided by drug manufacturers. The AKS limits the ability of manufacturers to provide coupons or discounts to patients enrolled in government health care programs, prohibiting manufacturers from providing direct subsidies to offset their out-of-pocket expenses for copayments and deductibles.¹⁹⁰ Although free drug programs for financially needy patients have historically not raised extensive concerns under anti-kickback laws, the HHS OIG, which is tasked with identifying and combating waste, fraud, and abuse within HHS, has articulated concerns with PAPs related to Medicare Part D.¹⁹¹ For example, PAPs and copayment coupons may increase costs to the federal government under Medicare Part D because cost-sharing subsidies for Part D-covered drugs that count toward patients’ true out-of-pocket expenses (“TrOOP”) will increase the number of beneficiaries who qualify for catastrophic benefit in any given coverage year and the point during the year at which they reach the catastrophic benefit.¹⁹² PAPs may

also have the effect of locking beneficiaries into the manufacturer's products, even if there are other equally effective, less costly alternatives, and patients may transition from a PAP to a government program such as Medicare Part D at some point in time.¹⁹³ OIG reiterated its position against manufacturer assistance related to Medicare Part D as recently as 2020, finding a proposal to provide copay assistance to Part D beneficiaries would be "highly suspect" under the AKS.¹⁹⁴ The OIG has also scrutinized charitable organizations that are not truly independent from manufacturer donors.¹⁹⁵ For example, OIG is concerned about independent charity PAPs defining disease-specific funds so narrowly that a donor earmarking funds for a given disease fund effectively results in subsidization of the donor's own products.¹⁹⁶ In 2021 and 2020, OIG issued favorable advisory opinions regarding financial support for high-cost, potentially curative gene and cell therapies, where the programs provide assistance ranging from covering administration of one-time treatment to providing wrap-around services, such as transportation and housing during treatment.¹⁹⁷

B. Coverage of off-label use

In general, drug products must have FDA approval to be reimbursed by public or private payers. Coverage for "off-label" use of approved products – drugs used for a different disease or medical condition, given in a different way, or given in a different dose than specified in the approved label¹⁹⁸ – may be available in certain circumstances. For example, Medicare Part D covers drugs prescribed for off-label use if the drugs are listed in CMS-recognized compendia for determining medically accepted indications.¹⁹⁹ Under Part B, reimbursement for off-label use is permitted if the MAC determines the use to be medically accepted, taking into account the major drug compendia, authoritative medical literature, and/or accepted standards of medical practice.²⁰⁰ State Medicaid programs mandate coverage of off-label uses where the drug is listed in CMS-recognized compendia.²⁰¹ Additionally, many states also currently require Medicaid programs and private payers to cover off-label use of drugs that meet certain criteria, with some requiring off-label coverage only for certain disease states such as cancer or other life-threatening or chronic and seriously debilitating conditions, and others mandating off-label coverage more broadly.²⁰² Off-label use is particularly widespread in oncology, where payers often use independent National Comprehensive Cancer Network Drugs and Biologics Compendium ("NCCN") guidelines to cover off-label treatments.

Off-label use remains controversial. On the one hand, off-label use may represent a physician's determination regarding which treatment would be medically appropriate for a given patient and is an important aspect of the physician-patient relationship. On the other hand, many off-label uses are being prescribed without strong evidence of their safety or efficacy in treating the off-label indication, raising patient safety concerns.²⁰³ In any case, communications regarding off-label use outside of the physician-patient relationship are highly regulated, and manufacturers are prohibited from promoting drug products for any off-label use (although certain communications with payers or other communications consistent with labeling may be permissible).²⁰⁴

C. Expanded access and right to try

Even if reimbursement for unapproved drugs is not available, patients may gain access to investigational drug products through FDA's expanded access or "compassionate use" program. Expanded access allows patients with an immediately life-threatening condition or serious disease or condition to gain access to an investigational medical product (drug, biologic, or medical device) for treatment outside of clinical trials when no comparable or satisfactory alternative therapy options are available.

There are three types of expanded access INDs: individual patient expanded access INDs,

including for emergency use;²⁰⁵ intermediate-size patient population expanded access INDs;²⁰⁶ and treatment INDs for widespread use.²⁰⁷ In all cases of expanded access use, FDA must determine that: (1) the patient(s) to be treated “have a serious or immediately life-threatening disease or condition, and there is no comparable or satisfactory alternative therapy”; (2) the potential patient benefit justifies the potential risks, and the risks are reasonable given the disease or condition to be treated; and (3) granting the expanded access “will not interfere with the initiation, conduct, or completion of clinical investigations that could support marketing approval of the expanded access use or otherwise compromise the potential development of the expanded access use”.²⁰⁸ Additional criteria apply to each type of expanded access.

As a separate pathway, federal and state “right to try” laws permit patients with life-threatening diseases to access certain unapproved therapies without going through the FDA expanded access process. Following recent enactment of state-level laws in a significant majority of states,²⁰⁹ the federal Right to Try Act was signed into law in 2018 to permit access to investigational drugs.²¹⁰ Under the federal Act, eligible patients must be diagnosed with a life-threatening disease or condition, have exhausted approved treatment options and be unable to participate in a clinical trial involving the eligible investigational drug, and have provided written informed consent.²¹¹ Manufacturers have discretion over whether to make their products available to patients who qualify for access under the law.

D. Digital health solutions

Manufacturers are also increasingly looking toward digital health tools to facilitate access to prescription drugs and improve communications and outcomes across the care continuum. Digital health solutions encompass a wide range of items and services, ranging from telehealth services to phone applications (“apps”) to wearables (i.e., Fitbit) to prescription digital therapeutics. Manufacturers may utilize digital health for real-time data generation as well as personalizing products and services for patients. Where appropriate, certain digital health tools may qualify in and of themselves for coverage and reimbursement (e.g., prescription digital therapeutics).

Policy issues that affect pricing and reimbursement

Cost of innovation, U.S. drug pricing, and “Foreign Underpricing”

Amidst global controversy over the high prices of innovative drug products, there is increasing debate regarding whether drug prices reflect the cost of innovation and, if so, whether this cost is appropriately distributed. The anticipated cost of developing a new drug, inclusive of capital costs and money spent on candidate drugs that fail to reach the market, has been estimated to range from less than \$1 billion to more than \$2 billion, and only about 12% of drugs succeed in the clinical trial process.²¹² According to one study, the cost to develop a new prescription drug that gains marketing approval is estimated to be \$2.6 billion as of 2013.²¹³ This is a significant increase from \$802 million in 2003 (approximately \$1 billion in 2013 dollars), representing a 145% increase in the 10-year time period between studies. Accounting for post-approval R&D, the cost of total development increases to nearly \$2.9 billion.²¹⁴ Key drivers of this significant price tag include high failure rates for potential clinical drug candidates (an estimated seven out of eight compounds that enter the clinical testing pipeline fail in development) as well as high out-of-pocket clinical costs for drug trials, including increased complexity or clinical trial design and larger trials, higher cost of inputs, increased focus on targeting chronic and degenerative diseases, changes in protocol design to include efforts to gather HTA information, and testing on comparator drugs to accommodate payer demands for comparative effectiveness data.²¹⁵

The cost of innovation appears to fall disproportionately on the U.S., where drug prices far outpace prices in other countries. In 2020, the CEA issued a report evaluating how the costs and benefits of medical innovation are distributed across developed nations. According to the CEA, while “[t]he U.S. Government and the biopharmaceutical industry have been critical to improving health worldwide by leading the way in the [R&D]”, “foreign countries often do not make equal investments in the R&D that is necessary to fuel innovation and ensure the economic viability of biopharmaceutical products”.²¹⁶ The report found that foreign “free-riding” has increased over the past 15 years, with patented drug prices in European countries falling from 51% of U.S. prices in 2003 to about 32% of U.S. prices in 2017.²¹⁷ The CEA concluded that “[f]oreign governments have implemented stricter price controls, enabling these products to be sold below fair market value, with Americans picking up the tab for making the availability of such products feasible in the first place”, leading to a “slower pace of innovation” and “fewer potential new life-saving therapies for patients in all countries”.²¹⁸ By contrast, “[r]educing foreign price controls would increase profits and innovation, thereby leading to greater competition and lower prices for U.S. patients”.²¹⁹

Addressing U.S. drug prices has been the subject of significant debate. Reform proposals range from addressing payment and reimbursement of drug prices in the U.S., to exercising trade policy tools to combat drug pricing practices in foreign markets.²²⁰ Additionally, states are actively considering proposals that would address drug pricing practices by a variety of mechanisms. These issues are explored in more detail in the following section on emerging trends.

Emerging trends

Tying U.S. drug prices to international prices

Given disparities between U.S. and ex-U.S. drug prices, a number of proposals seek to require drug prices for certain U.S. payers to be based on prices in international markets, a practice referred to as “reference pricing”. For example, the Trump administration issued an interim final rule, commonly referred to as the Most Favored Nation Final Rule (“MFN Rule”), which would have tied Medicare Part B payments for certain drugs to the lowest price paid in other economically advanced countries.²²¹ The MFN Rule was set to take effect on January 1, 2021; however, several courts enjoined the rule. Although CMS contended that it had good cause to proceed without notice-and-comment rulemaking, the courts determined that CMS’ omission of notice and comment likely violated the Administrative Procedure Act (“APA”).²²²

Reference pricing has also been contemplated in legislative proposals. For example, the Elijah E. Cummings Lower Drug Costs Now Act, passed by the U.S. House of Representatives in December 2019 and reintroduced to Congress in April 2021, is a Democratic proposal with several significant provisions related to drug pricing. In Title I, the bill gives HHS authority to directly negotiate prices for up to 250 drugs posing the greatest total cost to Medicare and the U.S. health system, and the maximum price set for such negotiations would be 1.2 times the average price of the drug in six foreign countries (Australia, Canada, France, Germany, Japan, and the United Kingdom) (or 85% of the AMP, where reference prices are not available).²²³ Such pricing would apply to Medicare and other federal programs, as well as non-federal government plans. The Act includes steep penalties for drug companies that do not participate in the negotiation process or abide by the agreed-on price.²²⁴

Drug importation

In addition to relying on drug prices used abroad, the U.S. has also adopted new policies permitting importation of drugs. In fall 2020, the Trump administration issued a final rule

and FDA guidance for industry creating two new pathways for the importation of drugs from Canada and other countries. The final rule enables states and Indian tribes to develop importation programs for approval by FDA, in which wholesalers and pharmacists may import prescription drugs from Canada. The final rule also necessitates that importation sponsors demonstrate how their programs will reduce covered prescription drug costs in the United States.²²⁵ FDA guidance creates a second pathway whereby manufacturers could import certain FDA-approved drugs that they sell abroad that are the same as U.S. versions. Under this pathway, manufacturers may utilize a new NDC for the imported products, which was intended to provide an avenue to lower the imported drugs' price compared to what the manufacturer's current distribution contracts necessitate.²²⁶

The importation rule was effective November 30, 2020; however, the Pharmaceutical Research and Manufacturers of America ("PhRMA") challenged the rule based on safety and other concerns. PhRMA's complaint alleges that the certification and final rule provide insufficient justification and evidence to meet the certification criteria specified in the Federal Food, Drug, and Cosmetic Act that the importation of drugs will "pose no additional risk to the public's health and safety" and will "result in a significant reduction in the cost" of the drugs for the American consumer. The complaint also alleges that the drug-tracing provisions of the final rule will create administrative and operational issues that undermine public health and safety.²²⁷ The final rule has also been met with resistance from Canadian officials, who have issued an interim order barring exportation of certain drugs if doing so would lead to or exacerbate a shortage in Canada.²²⁸ President Biden supported drug importation during his campaign, and the government moved to dismiss the complaint on standing and ripeness grounds on May 28, 2021.²²⁹

Additional proposals related to drug pricing reform in the U.S.

Federal and state policymakers have considered a number of additional proposals related to drug pricing reform. For example, in addition to setting forth Medicare negotiation provisions that cap negotiated prices at international reference prices, the Lower Drug Costs Now Act includes separate reform proposals, such as an out-of-pocket cap for Medicare Part D drugs, redesigning the Part D benefit and manufacturer discounts under the program, and limiting price increases to the inflation rate.²³⁰ Separate legislative proposals, such as the Prescription Drug Pricing Reduction Act ("PDPRA"), would similarly include limits on price increases above inflation and out-of-pocket caps, as well as other proposals related to Part B payments (reducing payment for new single-source drugs from 106% to 103% of WAC, among other changes), and information disclosure, among other proposals.²³¹

The Biden administration, as of June 2021, has yet to introduce significant drug pricing policies and did not include specific proposals in the "human infrastructure plan".²³² During the campaign, President Biden's platform included a number of proposals consistent with the Lower Drug Costs Now Act, such as a Part D out-of-pocket drug costs cap, Part D negotiation provisions, and limiting price increases to the inflation rate. The Biden campaign also put forward a proposal to establish drug pricing via an independent review board, which could include foreign reference pricing as a back stop, based on the German model for setting drug prices through negotiations between manufacturers and insurers.²³³ Additionally, President Biden has committed to maintaining or expanding coverage and protections under the ACA,²³⁴ which was the most significant regulatory overhaul and expansion of coverage since the creation of Medicare and Medicaid in 1965. The ACA has been repeatedly challenged in various court cases including before the Supreme Court, and in the most recent case (decided in June 2021), the Supreme Court held that the individual plaintiffs and states lacked standing to challenge the constitutionality of the ACA.²³⁵

States have also been active with respect to drug pricing reform proposals. Most notably, a significant number of states have proposed and enacted transparency laws that require manufacturers, PBMs, insurers, and other entities to report certain drug pricing information to state agencies.²³⁶ While reporting requirements vary by state, these laws generally require manufacturers to report information regarding drug prices and drug price increases above a certain threshold. For example, California requires manufacturers to report price increases exceeding 16% of WAC.²³⁷ Several states also require reporting upon the introduction of new prescription drugs to market with a WAC that exceeds the Medicare Part D specialty drug threshold.²³⁸ States have adopted other mechanisms for price reporting, such as authorizing an independent board to compile a list of drugs on which the state spends significant dollars and/or for which the WAC has increased significantly over a period of time.²³⁹ States are also considering and adopting proposals related to international reference pricing, generic manufacturing, drug importation, anti-price gouging and price increase penalties. Although state laws related to drug pricing are proliferating, a number of these laws have been subject to legal challenges or struck down by the courts.²⁴⁰

Impact of COVID-19 on pharmaceutical pricing and reimbursement

The COVID-19 pandemic has wide-ranging implications for the life sciences industry. The pandemic highlighted the need for manufacturers of finished medical products and suppliers of raw materials, components, and critical services to fortify supply chains, develop surge capacity, and implement other measures to prevent drug shortages. The pandemic also gave new insights into the need to navigate expedited development programs, unique access pathways (in particular, emergency use authorization), and related coverage pathways outside of the traditional routes of reimbursement and insurance coverage. In addition, the expansion of telehealth and digital prescribing during the pandemic may lead to the development of new policies enabling reimbursement for such services.²⁴¹

In the context of COVID-19, the U.S. government has been acquiring medical products, including vaccines and therapeutics, directly from manufacturers. In the future, there may be an expansion of the U.S. government's procurement of innovative medical products (e.g., novel gene and cell therapies and new vaccine technologies) to enhance the government's ability to respond to epidemics and pandemics.²⁴² Manufacturers should monitor how changes necessitated by the pandemic may affect traditional market access pathways during and after the public health emergency.

Successful market access

As demonstrated by this chapter, the drug pricing and reimbursement infrastructure in the U.S. consists of a complex patchwork of policies and institutions. Successful market access requires navigating this infrastructure in a way that ensures drug products are available to patients, reimbursable by patients' health care plans, and appropriately valued. These efforts must be compliant with various overlapping regulatory requirements and minimize enforcement risk under the AKS, FCA and other federal and state laws.²⁴³

Accordingly, drug manufacturers and investors funding development of drug products should consider the following in designing both U.S. and global market access strategies:

- **Access.** Manufacturers should evaluate the criteria for favorable coverage under various private and public plans and coordinate appropriate engagement with PBMs facilitating coverage with these payers, as well as the relative use by patients who are covered under government *versus* private payers and the likely settings of care for one time or chronic use of the product. Successful market access strategies will include plans for patient

assistance and patient support services, pharmacy and wholesaler distribution networks, and other key features facilitating access to drug products.

- **Pricing.** Manufacturers should investigate the coverage, coding, and payment structures that will apply to their drug products for each payer type in the U.S. Pricing strategies should include conducting a reimbursement assessment, including comprehensive coding and payment analysis across all relevant settings of care, and developing rebate bidding and contracting strategies, preparing payer budget impact moles, conducting payer market research, and using HCEI to support the proposed pricing structure. Manufacturer list and net pricing scenarios for new products must account for all supply chain concessions over a multi-year time horizon with growing limitations on ability to increase pricing year over year, as well as model impacts based on government price reporting obligations (e.g., best price, AMP, and ASP) and mandatory rebate liabilities (e.g., MDRP).
- **Value.** Manufacturers should develop appropriate evidence, including real world evidence, and messaging to communicate the value proposition for their drug products, including by developing a thorough understanding of the prescribing pathway, comparator treatments, quality measures, patient need, and direct and indirect costs of treatment with the new drug. Manufacturers should prepare to demonstrate the cost-effectiveness of drug products, in the event of a potential ICER assessment or requests for such information from payers more generally. Consideration should be given to potential value-based pricing structures that link the purchase price to patient outcomes and product warranties, as well as provide more predictable cost outlays for both government and private payers.

If possible, manufacturers should develop U.S. market access strategies at least two years before approval and launch in the U.S. and integrate these strategies with global market access efforts. When appropriately structured, market access strategies can inform clinical development and clinical trial outputs, help guide positioning during the drug approval process, and facilitate market entry upon approval. Market access strategies also should include frequent review and updates based on changes in the U.S. reimbursement framework. The payers and programs involved in drug coverage and reimbursement are constantly evolving, and current or future proposals for reform and growing government enforcement activity focused on market access could significantly impact drug pricing in the U.S.

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28. Council of Econ. Advisers, *Funding the Global Benefits to Biopharmaceutical Innovation* 11 (Feb. 2020), <https://www.whitehouse.gov/wp-content/uploads/2020/02/Funding-the-Global-Benefits-to-Biopharmaceutical-Innovation.pdf>.
29. *Id.*
30. 21 U.S.C. § 393(b)(1)–(2). FDA initially was established as the Bureau of Chemistry within the Department of Agriculture with the 1906 Pure Food and Drugs Act. Pub. L. No. 59-384, 34 Stat. 768, (1906). The 1906 Act banned interstate traffic in adulterated and mislabeled products, provided criminal penalties for violations, and authorized the seizure of offending products, but did not authorize the FDA to require premarket testing or approval for new drug products. The agency assumed its current gatekeeper role through the 1938 Federal Food, Drug, and Cosmetics Act (“FDCA”). Pub. L. No. 75-717, 52 Stat. 1040 (1938) (codified as amended in scattered sections of 21 U.S.C.). The original FDCA required manufacturers to notify the agency and submit evidence of safety before marketing new drugs to the public. The subsequent 1962 Amendments transformed this premarket *notification* system in a premarket *approval* system, under which the agency must affirmatively approve new drugs on the basis of safety and efficacy. Drug Amendments of 1962, Pub. L. No. 87-781, 76 Stat. 780 (1962); see also, e.g., Richard A. Merrill, *The Architecture of Government Regulation of Medical Products*, 82 VA. L. REV. 1753, 1764–65 (1996).
31. *Fact Sheet: FDA at a Glance*, U.S. FOOD & DRUG ADMIN. (Nov. 2020), <https://www.fda.gov/media/143704/download>.
32. 21 U.S.C. § 355 (NDAs); 42 U.S.C. § 262 (BLAs).

33. 21 U.S.C. § 355(d) (NDAs); 42 U.S.C. § 262(a)(2)(C) (BLAs).
34. 21 U.S.C. § 355(j) (ANDAs); 42 U.S.C. § 262(k) (biosimilar applications).
35. 21 U.S.C. § 355(j)(8)(B) (ANDAs); 42 U.S.C. § 262(i)(2)(B) (biosimilar applications).
36. *Novel Drug Approvals for 2020*, U.S. FOOD & DRUG ADMIN., <https://www.fda.gov/drugs/new-drugs-fda-cders-new-molecular-entities-and-new-therapeutic-biological-products/novel-drug-approvals-2020> (content current as of Jan. 13, 2021) (noting approval of 53 drug and biological products by the Center for Drug Evaluation and Research, and excluding from this list vaccines, allergenic products, blood and blood products, plasma derivatives, cellular and gene therapy products, or other products approved by the Center for Biologics Evaluation and Research); *2020 Biological License Application Approvals*, U.S. FOOD & DRUG ADMIN., <https://www.fda.gov/vaccines-blood-biologics/development-approval-process-cber/2020-biological-license-application-approvals> (content current as of Aug. 20, 2020) (noting approval of 8 biological products); *2020 First Generic Drug Approvals*, U.S. FOOD & DRUG ADMIN., <https://www.fda.gov/drugs/first-generic-drug-approvals/2020-first-generic-drug-approvals> (content current as of Feb. 23, 2021) (defining “first generics” as the first approval by FDA which permits a manufacturer to market a generic product in the United States); *Biosimilar Product Information*, U.S. FOOD & DRUG ADMIN., <https://www.fda.gov/drugs/biosimilars/biosimilar-product-information> (content current as of Dec. 17, 2020).
37. Pub. L. No. 102–571, 106 Stat. 4491 (1992).
38. *Fact Sheet: FDA at a Glance*, U.S. FOOD & DRUG ADMIN., <https://www.fda.gov/about-fda/fda-basics/fact-sheet-fda-glance> (content current as of Nov. 20, 2020).
39. U.S. FOOD & DRUG ADMIN., PDUFA REAUTHORIZATION PERFORMANCE GOALS AND PROCEDURES FISCAL YEARS 2018 THROUGH 2022 6, <https://www.fda.gov/media/99140/download> (last visited May 13, 2020).
40. *Id.*
41. Priority review is also available to manufacturers that have a priority review voucher or where other criteria are met. *See, e.g., Guidance for Industry, Expedited Programs for Serious Conditions—Drugs and Biologics*, U.S. FOOD & DRUG ADMIN., 24–25 (May 2014), <https://www.fda.gov/media/86377/download>.
42. 21 U.S.C. §§ 356(a) (breakthrough therapy designation), 356(b) (fast track designation), 356(c) (accelerated approval); *see also* 21 C.F.R. part 314, subpart H; 21 C.F.R. part 601, subpart E; U.S. Food & Drug Admin. *Guidance for Industry, Expedited Programs for Serious Conditions—Drugs and Biologics* (May 2014), <https://www.fda.gov/media/86377/download>. Additional pathways and designations may also be available. *See, e.g.,* 21 U.S.C. §§ 356(g) (Regenerative Advanced Therapy designation), 356(h) (Limited Population Pathway for Antibacterial and Antifungal Drugs), 355f(d) (Qualified Infectious Disease Product designation).
43. 21 U.S.C. §§ 355(c)(3)(E)(ii), 355(j)(5)(F)(ii); 21 C.F.R. § 314.108.
44. 21 C.F.R. § 314.108(b)(2). An NDA or ANDA can be submitted after four years if it contains a certification of patent invalidity or noninfringement.
45. 21 U.S.C. §§ 355(c)(3)(E)(iii), 355a(b), 360cc(a); 42 U.S.C. § 262(k)(7); 21 C.F.R. §§ 314.108, 316.31.
46. 21 U.S.C. §§ 360n, 360ff, 360bbb-4a.
47. In many cases, the definitions provided herein are summaries of statutory or regulatory definitions.
48. 42 C.F.R. § 447.502.
49. 42 U.S.C. § 1396r-8(k)(1).

50. *Id.* § 1395w-3a(c)(1).
51. *Pricing Policy Update: Important Information About AWP Data*, WOLTERS KLUWER, <https://www.wolterskluwer.com/en/solutions/medi-span/about/pricing-policy-update> (last visited June 2, 2021).
52. 42 U.S.C. § 1396r-8(c)(1)(C).
53. *Id.* § 1395w-3a(c)(6)(B).
54. Social Security Amendments of 1965, Pub. L. No. 89-97, tit. XVIII, 79 Stat. 286, 291–343 (1965).
55. 42 U.S.C. § 1395y(a)(1)(A).
56. *Id.* § 1395c *et seq.*
57. *Id.* § 1395kk-1.
58. *Id.* §§ 1395ff(f)(1)(B), 1395ff(f)(2)(B); *see also* Ctrs. for Medicare & Medicare Servs., *Medicare Program Integrity Manual*, ch. 13, § 13.1.1, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c13.pdf> (last updated Feb. 12, 2019).
59. 42 U.S.C. § 1395j *et seq.*
60. *Id.* § 1395k(a).
61. Some low-income beneficiaries may qualify for premium and cost-sharing assistance, either by qualifying for full Medicaid benefits or Medicare Savings Programs. *Id.* § 1396u-3.
62. *Id.* § 1395kk-1.
63. *Id.* §§ 1395j-1395w-6.
64. *Id.* § 1395w-21. MA plans are either local plans that serve a particular area, or regional plans that contract with CMS to provide services to one or more defined regions. Beneficiaries may choose to enroll in MA if there is a plan offered in their area. *Id.* § 1395w-28(4)–(5).
65. *Id.* § 1395w-22(a).
66. *Id.* § 1395w-22(a)(3); 42 C.F.R. § 422.100(c).
67. 42 U.S.C. § 1395w-131.
68. *Id.* § 1395w-101.
69. *Id.* § 1395w-104(b)(3)(C); *see also id.* § 1395w-104(b)(3)(G) (setting forth specified categories for which plans must include all covered Part D drugs). CMS automatically approves formulary classification systems that are consistent with the U.S. Pharmacopeia (“USP”) category and class system. Alternative classification systems must be reviewed by CMS to determine if they are sufficiently similar to the USP or other common systems, such as the American Hospital Formulary Service classification system. *See* Ctrs. for Medicare & Medicaid Servs., *Medicare Prescription Drug Benefit Manual*, ch. 6 § 30.2.1, <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Part-D-Benefits-Manual-Chapter-6.pdf> (last updated Jan. 1, 2016).
70. 42 C.F.R. § 423.272(b)(2); *see generally* CONG. RESEARCH SERV., R40611, *MEDICARE PART D PRESCRIPTION DRUG BENEFIT* (2018).
71. 42 U.S.C. § 1395y(a)(1)(A); 42 C.F.R. § 411.15(k).
72. 42 U.S.C. § 1395w-102(e); 42 C.F.R. § 423.100.
73. 42 U.S.C. § 1395ff.
74. Ctrs. for Medicare & Medicaid Servs., *Medicare Program Integrity Manual*, ch. 13, § 13.2.2.3, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c13.pdf> (last updated Feb. 12, 2019).

75. Ctrs. for Medicare & Medicaid Servs., *Medicare Prescription Drug Manual*, ch. 6, § 30, <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Part-D-Benefits-Manual-Chapter-6.pdf> (last updated Jan. 15, 2016); *see also* Ctrs. for Medicare & Medicaid Servs., *Medicare Managed Care Manual*, ch. 4, § 10.1, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf> (last updated Apr. 22, 2016) (referring to the “Medicare Prescription Drug Manual” for requirements prescription drug coverage).
76. 42 U.S.C. § 1395w-104(b)(3)(A); 42 C.F.R. § 423.120(b)(1); *see also* Ctrs. for Medicare & Medicaid Servs., *Medicare Prescription Drug Benefit Manual*, ch. 6, § 30.1.5, <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Part-D-Benefits-Manual-Chapter-6.pdf> (last updated Jan. 15, 2016).
77. 42 C.F.R. § 423.120(b)(2)(i).
78. 42 U.S.C. § 1395w-104(b)(3)(G)(iv). These classes of drugs are often referred to as “protected classes”.
79. Social Security Amendments of 1983, Pub. L. No. 98-21, 97 Stat. 65 (1983).
80. 42 U.S.C. § 1395cc(a)(1)(H).
81. 42 C.F.R. § 412.2.
82. *Id.* § 412.60.
83. *Id.* § 412.2(f).
84. *Id.* §§ 412.150-412.172.
85. *Id.* § 412.22.
86. Medicare Payment Advisory Comm’n, *Hospital Acute Inpatient Services Payment System 2* (Oct. 2019), http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_19_hospital_final_v2_sec.pdf?sfvrsn=0.
87. *See* 42 U.S.C. §§ 1395k(a)(1) (providing for coverage of medical or other health services), 1395x(s)(2) (defining medical and other health services to include drugs not usually self-administered).
88. 42 C.F.R. § 419.2(a).
89. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (2003).
90. 42 U.S.C. § 1395w-3a(b). For certain drug products that lack ASP data, reimbursement payments may be calculated using the WAC. *Id.* § 1395w-3a(c)(4). WAC may also be used if lower than the ASP. *Id.* § 1395w-3a(b)(4).
91. *Id.* § 1395w-3a(c)(1).
92. *Id.* § 1396r-8(b)(3).
93. For example, manufacturers of products paid as drugs under Part B but considered devices by Medicaid (and FDA) often do not have rebate agreements and thus would not be required to report ASPs. *See, e.g.*, Office of Inspector General, *Limitations in Manufacturer Reporting of Average Sales Price Data for Part B Drugs*, OEI-12-13-00040, 8 n.24 (July 2014), <https://oig.hhs.gov/oei/reports/oei-12-13-00040.asp>.
94. Ctrs. for Medicare & Medicaid Servs., *Medicare Claims Processing Manual*, ch. 17, § 20.1.2, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf> (updated Aug. 30, 2019).
95. 42 U.S.C. § 1395w-3a(b); 42 C.F.R. § 414.904. The Budget Control Act of 2011 included sequestration requirements that reduced the payment rate for Part B to 4.3%. *See* Pub. L. No. 112-25, § 302, 125 Stat. 240, 256, 258-59 (2011). Additionally, for new drug products reporting WAC instead of ASP, the statutory reimbursement rate for these drugs is WAC plus 3%. 42 U.S.C. § 1395w-3a(c)(4) (amended from WAC plus 6% pursuant to Sustaining Excellence in Medicaid Act of 2019, Pub. L. No. 116-39, § 6, 133 Stat. 1062 (2019), following CMS rulemaking that had previously reduced this amount).

96. 42 U.S.C. § 1395l(a)(1).
97. 42 C.F.R. § 419.2(b); Ctrs. for Medicare & Medicaid Servs., *Medicare Claims Processing Manual*, ch. 17, § 20.1.3, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf> (last updated Aug. 30, 2019).
98. Ctrs. for Medicare & Medicaid Servs., *Medicare Claims Processing Manual*, ch. 17, § 10, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf> (last updated Aug. 30, 2019).
99. 42 U.S.C. § 1395u(o)(1)(C); 84 Fed. Reg. 61,142, 61,145 (Nov. 12, 2019). The reimbursement rate of ASP minus 22.5% for 340B-acquired Part B drugs is currently being challenged in federal court. *See American Hosp. Ass'n v. Azar*, 385 F. Supp. 3d. 1 (D.D.C. 2019).
100. 42 U.S.C. § 1395w-23; 42 C.F.R. § 422.304.
101. 42 C.F.R. § 422.304(b).
102. 42 U.S.C. § 1395w-102(a).
103. 42 C.F.R. § 423.104.
104. The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 3301-3315, 124 Stat. 119, 461-80 (2010).
105. For brand-name drug products purchased by beneficiaries in the coverage gap, manufacturers provide a 70% discount and Medicare pays an additional 5%. For generic drug products, Medicare pays 75% of the cost. Ctrs. for Medicare & Medicaid Servs., *2020 Medicare Advantage and Part D Advance Notice Part 2 and Draft Call Letter* (Jan. 30, 2019), <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2020Part2.pdf>.
106. 42 U.S.C. § 1395w-114.
107. *See* Ctrs. for Medicare & Medicaid Servs., *Announcement of Calendar Year (CY) 2022 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies* (Jan. 15, 2021), <https://www.cms.gov/files/document/2022-announcement.pdf>.
108. Medicare Payment Advisory Comm'n, *Report to Congress: Medicare Payment Policy* 413 (March 2021), http://medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf.
109. 42 U.S.C. § 1395w-115.
110. Cong. Research Serv., R40611, Medicare Part D Prescription Drug Benefit (2018).
111. 42 U.S.C. § 1395w-111(i).
112. Medicare Payment Advisory Comm'n, *Part D Payment System* 3 (2019), http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_19_partd_final_sec.pdf?sfvrsn=0.
113. Social Security Amendments of 1965, Pub. L. No. 89-97, tit. XIX, 79 Stat. 286, 343–53 (1965).
114. 42 U.S.C. § 1396a.
115. *Id.* § 1396a(a)(10). Other statutes and regulations promulgated by CMS also defined eligibility pathways. *See, e.g., id.* § 1396v; 42 C.F.R. Part 435.
116. 42 U.S.C. §§ 1396b(m), 1395mm(a)(1).
117. *Id.* §§ 1396a, 1396u-7.
118. *Id.* §§ 1396a(a)(54), 1396u-7(b)(2)(A).
119. *See Medicaid Benefits: Over-the-Counter Products*, KAISER FAMILY FOUND., <https://www.kff.org/other/state-indicator/medicaid-benefits-over-the-counter-products/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited May 14, 2020).

120. 42 U.S.C. § 1396u-5(d)(1).
121. *See generally id.* § 1396r-8.
122. *Id.* § 1396r-8(a)-(b).
123. *Id.* § 1396r-8(d)(2).
124. 42 C.F.R. § 447.53.
125. Medicaid Program: Covered Outpatient Drugs, 81 Fed. Reg. 5,169, 5,174-76, 5,347 (Feb. 1, 2016) (codified at 42 C.F.R. § 447.502) (replacing the estimated acquisition cost (“EAC”) with AAC).
126. *Id.* at 5176.
127. 42 C.F.R. § 447.502.
128. 42 U.S.C. § 1396a(a)(30)(A).
129. Medicaid & CHIP Payment & Access Comm’n, *Medicaid Payment for Outpatient Prescription Drugs* 6 (May 2018), <https://www.macpac.gov/wp-content/uploads/2015/09/Medicaid-Payment-for-Outpatient-Prescription-Drugs.pdf>.
130. Rachel Dolan, *Understanding the Medicaid Prescription Drug Rebate Program*, Kaiser Family Found. (Nov. 12, 2019), <https://www.kff.org/medicaid/issue-brief/understanding-the-medicaid-prescription-drug-rebate-program/>.
131. For example, the Ohio state auditor released a report finding that state PBMs collected \$208 million in fees for generic Medicaid prescriptions paid my managed care plans between April 1, 2017 and March 31, 2018. *See* Ohio Auditor of State, *Ohio’s Medicaid Managed Care Pharmacy Services* 2 (Aug. 16, 2018), https://ohioauditor.gov/auditsearch/Reports/2018/Medicaid_Pharmacy_Services_2018_Franklin.pdf.
132. *See* 42 U.S.C. § 1396r-8(e)(4).
133. *See id.* § 1396r-8(e)(5); 42 C.F.R. § 447.514. If the FUL is less than the average AAC for retail community pharmacies, FUL is calculated using a higher multiplier to reflect average retail community pharmacies’ acquisition costs. 42 C.F.R. § 447.514.
134. Cong. Research Serv., R43778, *Medicaid Prescription Drug Pricing and Policy* 13 (2014).
135. 42 C.F.R. § 447.512(b).
136. 42 U.S.C. § 1396r-8(b).
137. *Id.* § 1396r-8(c).
138. *See*, Cong. Research Serv., R43778, *supra* note 134, at 17.
139. The 340B program was established in 1992 through section 340B of the Public Health Services Act. *See* Veterans Health Care Act of 1992, Pub. L. No. 102-585, § 602, 106 Stat. 4943, 4967-71 (1992) (enacting Section 340B of the Public Health Service Act). 340B is administered by Health Resources and Services Administration (“HRSA”), an agency within HHS, through HRSA’s Office of Pharmacy Affairs (“OPA”), and effectuated through the Pharmaceutical Pricing Agreement and addendum (collectively “PPA”).
140. Mike McCaughan, *The 340B Drug Discount Program*, Health Affairs (Sept. 14, 2017), <https://www.healthaffairs.org/doi/10.1377/hpb20171024.663441/full/>.
141. 42 U.S.C. § 256b.
142. *See, e.g.*, Rena M. Conti & Peter B. Bach, *The 340B Drug Discount Program: Hospitals Generate Profits By Expanding To Reach More Affluent Communities*, Health Affairs (Oct. 2014), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.0540>.
143. Pub. L. No. 111-148, § 7101, 124 Stat. 119, 821-22 (2010); Notice Regarding 340B Drug Pricing Program—Contract Pharmacy Services, 75 Fed. Reg. 10,272 (Mar. 5, 2010); Stephen Barlas, *Health Care Reform Bill Expands Access to Section 340B Discounted Drugs for Hospitals*, 35 *Pharmacy & Therapeutics* 632, 632–34 (2010).

144. Avalere, *Hospital Acquisitions of Physician Practices and the 340B Program* 4 (June 2015), <https://avalere.com/insights/avalere-white-paper-hospital-acquisitions-of-physician-practices-and-the-340b-program>.
145. Adam J. Fine, *Exclusive: 340B Program Purchases Reach \$24.3 Billion—7%+ of the Pharma Market—As Hospital Charity Care Flatlines*, Drug Channels (May 14, 2019), <https://www.drugchannels.net/2019/05/exclusive-340b-program-purchases-reach.html>; Adam J. Fine, *Exclusive: 340B Program Hits \$16.2 Billion in 2016; Now 5% of U.S. Drug Market*, Drug Channels (May 18, 2017), <https://www.drugchannels.net/2017/05/exclusive-340b-program-hits-162-billion.html>.
146. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, 82 Fed. Reg. 52,356, 52,362 (Nov. 13, 2017) (effective Jan. 1, 2018).
147. *American Hosp. Ass'n v. Azar*, 385 F. Supp. 3d 1 (D.D.C. 2019).
148. Michelle M. Stein, *Hospitals Ask Supreme Court To Take Up 340B, Site Neutral Pay Cuts*, InsideHealthPolicy (Feb. 11, 2021; 12:57 PM ET), <https://insidehealthpolicy.com/inside-drug-pricing-daily-news/hospitals-ask-supreme-court-take-340b-site-neutral-pay-cuts>.
149. *American Hosp. Ass'n v. Azar*, 967 F.3d 818 (D.C. Cir. 2020), *petition for cert. filed* Feb. 12, 2021 (No. 20-1114).
150. Tom Mirga, *HRSA Says its 340B Contract Pharmacy Guidance Is Not Legally Enforceable*, 340B Report (Jul. 9, 2020); Notice Regarding Section 602 of the Veterans Health Care Act of 1992; Contract Pharmacy Services, 61 Fed. Reg. 43,549, 43,550 (Aug. 23, 1996); Notice Regarding 340B Drug Pricing Program-Contract Pharmacy Services, 75 Fed. Reg. 10,272 (Mar. 5, 2010).
151. Hailey Mensik, *HHS Orders 6 Drugmakers to Repay Providers for Violating 340B*, HealthcareDive (May 18, 2021), <https://www.healthcaredive.com/news/hhs-orders-6-drugmakers-to-repay-providers-for-violating-340b/600353/>. *See generally* Court Order to Dismiss, *American Hosp. Ass'n v. Azar*, No. 4:20-cv-08806-YGR (C.D. Cal. 2021); *American Hosp. Ass'n Motion to Intervene, Astrazeneca Pharm. v. Azar*, C.A. No. 21-00027-LPS (D. Del. 2021).
152. Edward R. Berchick *et al.*, *Health Coverage in the United States: 2018*, U.S. Census Bureau 3 (Nov. 2019), <https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf>.
153. Pub. L. No. 111-148, § 1511, 124 Stat. 119, 252 (2010); *Minimum Value and Affordability*, Internal Revenue Serv., <https://www.irs.gov/affordable-care-act/employers/minimum-value-and-affordability> (last visited May 15, 2020).
154. Karen Pollitz *et al.*, *What's The Role of Private Health Insurance Today and Under Medicare-for-all and Other Public Option Proposals?*, Kaiser Family Found. (Jul. 30, 2019), <https://www.kff.org/health-reform/issue-brief/whats-the-role-of-private-health-insurance-today-and-under-medicare-for-all-and-other-public-option-proposals/>.
155. The Health Insurance Marketplaces were created under the ACA. *See* Pub. L. No. 111-148, 124 Stat. 119 (2010).
156. Many of those covered by government programs have some form of coverage through a private health insurer. This includes Medicaid enrollees covered by MCOs, which contract with MCOs, Medicare enrollees in Medicare Advantage Plans, and traditional Medicare enrollees who have supplemental private coverage, including Medicare Part D stand-alone prescription drug plans.
157. Cole Werble, *Health Policy Brief Series: Pharmacy Benefit Managers*, Health Affairs 1 (Sept. 2017), https://www.healthaffairs.org/doi/10.1377/hpb20171409.000178/full/healthpolicybrief_178.pdf.

158. See, e.g., U.S. Dep't of Health & Hum. Servs., *American Patients First: The Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs* (May 2018), <https://www.hhs.gov/sites/default/files/AmericanPatientsFirst.pdf>.
159. Fraud and Abuse: Removal of Safe Harbor Protection for Rebates Involving Prescription Pharmaceuticals, 84 Fed. Reg. 2,340 (Feb. 6, 2019); Fraud and Abuse; Removal of Safe Harbor Protection for Rebates Involving Prescription Pharmaceuticals and Creation of New Safe Harbor Protection for Certain Point-of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees, 85 Fed. Reg. 76,666 (Nov. 30, 2020).
160. *Pharm. Care Mgmt. Ass'n v. U.S. Dep't of Health & Hum. Servs.*, No. 1:21-cv-00095-JDB (D.D.C. Jan. 12, 2021); Fraud and Abuse; Removal of Safe Harbor Protection for Rebates Involving Prescription Pharmaceuticals and Creation of New Safe Harbor Protection for Certain Point-of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees, 86 Fed. Reg. 7,815 (Feb. 2, 2021).
161. U.S. Fed. Trade Comm'n, Federal Trade Commission Report on Rebate Walls 6 (May 28, 2021), https://www.ftc.gov/system/files/documents/reports/federal-trade-commission-report-rebate-walls/federal_trade_commission_report_on_rebate_walls_.pdf.
162. Neeraj Sood *et al.*, *Follow the Money: The Flow of Funds in the Pharmaceutical Distribution System*, Health Affairs Blog (June 13, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170613.060557/full/>.
163. Transcript, Drug Pricing in America: A Prescription for Change, Part III: Hearing Before the S. Comm. on Finance, 116th Cong. (Apr. 9, 2019) (unofficial transcript available through CQ.com) (statement of Senator Grassley, citing information reported by the U.S. Department of Justice).
164. See, e.g., *id.*; see also Statement of Steve Miller, M.D. Executive Vice President & Chief Clinical Officer Cigna Corporation, Drug Pricing in America: A Prescription for Change, Part III: Hearing Before the S. Comm. on Finance, 116th Cong. (Apr. 9, 2019), <https://www.finance.senate.gov/imo/media/doc/Cigna%20ExpressScripts%20Testimony%20of%20Steven%20Miller%20MD.pdf> (“The 2018 Cigna Value of Integration Study shows that clients with Cigna medical, pharmacy, and behavioral benefits reduce annual medical costs by an average of \$645 for each person with an identified health improvement opportunity—savings that can increase to nearly \$10,000 for individuals with certain chronic conditions.”).
165. *The Prescription Drug Landscape, Explored*, Pew Charitable Trust (Mar. 8, 2019), <https://www.pewtrusts.org/en/research-and-analysis/reports/2019/03/08/the-prescription-drug-landscape-explored>.
166. *Id.*
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