Drug Reimbursement Trends Report

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Foreword

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In recent years, the number of specialty medicines approved by the FDA has notably increased. Many of these medicines address conditions with historically high unmet needs and offer new hope to patients, however, they often present significant financial uncertainty for those same patients who are left unaware of their out-of-pocket costs until they receive an Explanation of Benefits (EOB) days or weeks after the encounter.

The Hospital Price Transparency and Transparency in Coverage rulings enacted by CMS in 2019 and 2020 respectively were designed to shed light on the true cost of care. By mandating the publication of machine-readable files (MRFs) containing negotiated reimbursement rates between payers and providers, these rulings aim to empower patients and healthcare stakeholders alike to improve visibility into healthcare pricing. Today, price transparency has received broad support in Washington, D.C. First initiated by the Trump administration, expanded by the Biden administration, and now subject to further enforcement efforts by the current administration, price transparency is one of the few bipartisan issues. At the time of publication, the current administration has issued multiple executive orders meant to accelerate compliance and the breadth of price transparency requirements, reaffirming it's here to stay.

In this Drug Reimbursement Trends Report, Turquoise Health and ZS have partnered to analyze reimbursement dynamics for a subset of specialty drugs administered by physicians across multiple high-cost therapy areas. The report focuses on medical benefit physician-administered drugs, as legislation does not yet require similar transparency reporting for pharmacy benefit products. We are optimistic that reporting requirements for pharmacy benefit drugs will be included in the near future.

The insights provided in this report aim to help manufacturers better understand customer economics and the impact on patient affordability. While there is still work to be done, we believe price transparency legislation is an encouraging step toward making healthcare costs more "shoppable" and arming patients with the information they need to make informed decisions about how and where they receive healthcare.

Scope of Report

Scope of Products

The report focused on 17 medical benefit products across four therapy areas (TAs): Oncology PD-1/PD-L1, Multiple Sclerosis, Respiratory, and the Trastuzumab biosimilar. The report examines the degree of reimbursement variation seen across products, providers, and payers.

Medical Benefit Products Examined

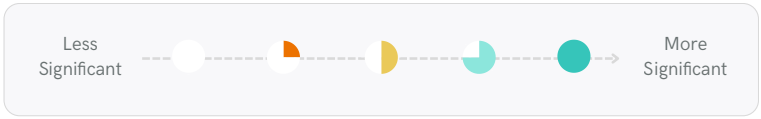
Oncology (PD-1/PD-L1)
Keytruda (J9271) Opdivo (J9299) Tecentriq (J9022) Imfinzi (J9173) Libtayo (J9119)
Respiratory
Nucala (J2182) Xolair (J2357) Fasenra (J0517) Tezspire (J2356)
Multiple Sclerosis
Ocrevus (J2350) Briumvi (J2329) Lemtrada (J0202) Tysabri (J2323)
Trastuzumab Biosimilars
Herceptin (J9355) Trazimera (Q5116) Ogivri (Q5114) Kanjinti (Q5117)

These TAs represent diversity across the following dimensions:

- **Budget Impact:** The degree to which the products within the market contribute to both payer and provider budget impact
- **Disease Severity:** The degree to which the disease impacts the duration or quality of life of the patient
- **Clinical Similarity:** The degree of clinical similarity (i.e., efficacy and safety) across products within the market basket
- **Payer Management:** The degree to which payers are actively managing the products within the market basket

Products were selected to explore a range of reimbursement insights, with the expectation that market baskets scoring higher on these dimensions might exhibit greater variability in reimbursement across products, providers, and payers.

The evaluations in **Figure 1** are informed by our expertise working with these products and are meant to support a directional comparison across TAs.



	Budget Impact	Disease Severity	Clinical Similarity	Payer Management
Oncology PD-1/PD-L1				
Multiple Sclerosis				
Respiratory				
Trastuzumab Biosimilars				

Figure 1

Scope of Data

Over 2 million records[1] were analyzed based on the NPI-level data provided by Turquoise Health. Each record of data represents a unique eligible reimbursement rate at the payer/plan + HCPCS code of product + NPI level.

Scope of Analysis

The analyses in this report provide insight into some of the frequently asked business questions surrounding reimbursement data and payer/provider dynamics.

We focused on a sample set of research questions to illustrate the types of insights that can be extracted from the data.

How does reimbursement vary across…

… similar products within the same therapy area?

… products in different therapy areas?

… provider sites of care?

… payer channels? Across individual payers?

… products within individual provider accounts?

… payers within individual provider accounts?

And ultimately, to what extent does differential reimbursement create incentives for payers or providers to manage products differentially?

Disclaimer

Despite various data transformations and validations performed by Turquoise Health, the data is limited by the quality of the data posted by hospitals and payers. This data may contain errors, omit information, or be duplicative. The data records represent eligible reimbursement rates and do not include the volume utilized. Therefore, we tend to see a similar distribution of reimbursement rates across provider types and payer types, regardless of the market basket. Any findings captured in the report may not capture the full diversity of the U.S. healthcare landscape.

In addition, any summary statistics surfaced in the report are not weighted by utilization. Lastly, negotiated rates do not always translate to final payment by the payer or guaranteed reimbursement as they do not account for the payer's utilization management policies or denials. A detailed methodology can be found in the Appendix.

1. A complete breakdown of the data by market basket is provided in Figure 13 in the Appendix.

Executive Summary

Differential reimbursement dynamics are more pronounced for products that are clinically similar

Reimbursement distributions are generally similar across TAs, though there is evidence that clinically similar products, such as biosimilars, are more likely to have variability in reimbursement premiums across products. These dynamics highlight an elevated importance of economic and non-clinical factors in payer and provider decision-making for clinically similar products.

Commercial reimbursement to hospitals is significantly higher compared to Medicare Advantage

Providers were >6× more likely to receive reimbursement rates >200% of ASP[2] for commercial patients than Medicare Advantage patients. This dynamic may create a perverse incentive for providers to prioritize commercial patients over Medicare patients.

Regional payers are more exposed to higher reimbursement rates than national payers

Reimbursement from regional payers is often 25% to 50% higher than reimbursement from national payers. Analysis of these dynamics at local level exposes how regional payer reimbursement is influenced by varying degrees of payer/provider control across geographies.

Hospitals are ~3× more likely to receive reimbursement rates >200% of ASP compared to specialty groups

When comparing across provider sites of care, hospitals have the highest average reimbursement. As higher reimbursement can often translate to higher patient costs, these dynamics emphasize the importance of supporting and sustaining the viability of lower-cost community healthcare settings, which tend to be reimbursed at lower rates.

All else equal, reimbursement dynamics can carry revenue implications for providers of up to >$100k per year for a single patient

Analysis of reimbursement across products illustrates how reimbursement dynamics add complexity to provider-level decision-making.

Price transparency data paves the way for shoppable healthcare in the future

This data empowers all stakeholders, including manufacturers, providers, payers, and patients, to make better-informed decisions, hopefully leading to more efficient, cost-effective, and accessible healthcare solutions.

2. The analyses in this report evaluate reimbursement for each product based on the premium to its own average selling price (ASP) on a per billing unit basis defined by CMS. This methodology allows for better comparison across products and therapy areas as it corrects differential pricing and dosing. For example, if a drug's ASP is $100 and the reimbursement is ASP+6%, the reimbursement amount would be $106. In this report, a reimbursement of $106 compared to an ASP of $100 is reflected as "106% of ASP."

Comparison Across Therapy Areas

Reimbursement across TAs is generally similar, with most reimbursement rates falling between 100–130% of ASP

Across all therapy areas (TAs), provider sites of care, and payer channels, national reimbursement distributions are generally similar across all four TAs when measured as a percentage of ASP. These distributions are mostly unimodal with most reimbursement falling between 100–130% of ASP. However, there is a consistent weak second mode of reimbursement >200% of ASP across all TAs that represents a long tail of providers receiving "very high" reimbursement (**Figure 2**).

National Reimbursement Rate Distribution Across Therapy Areas

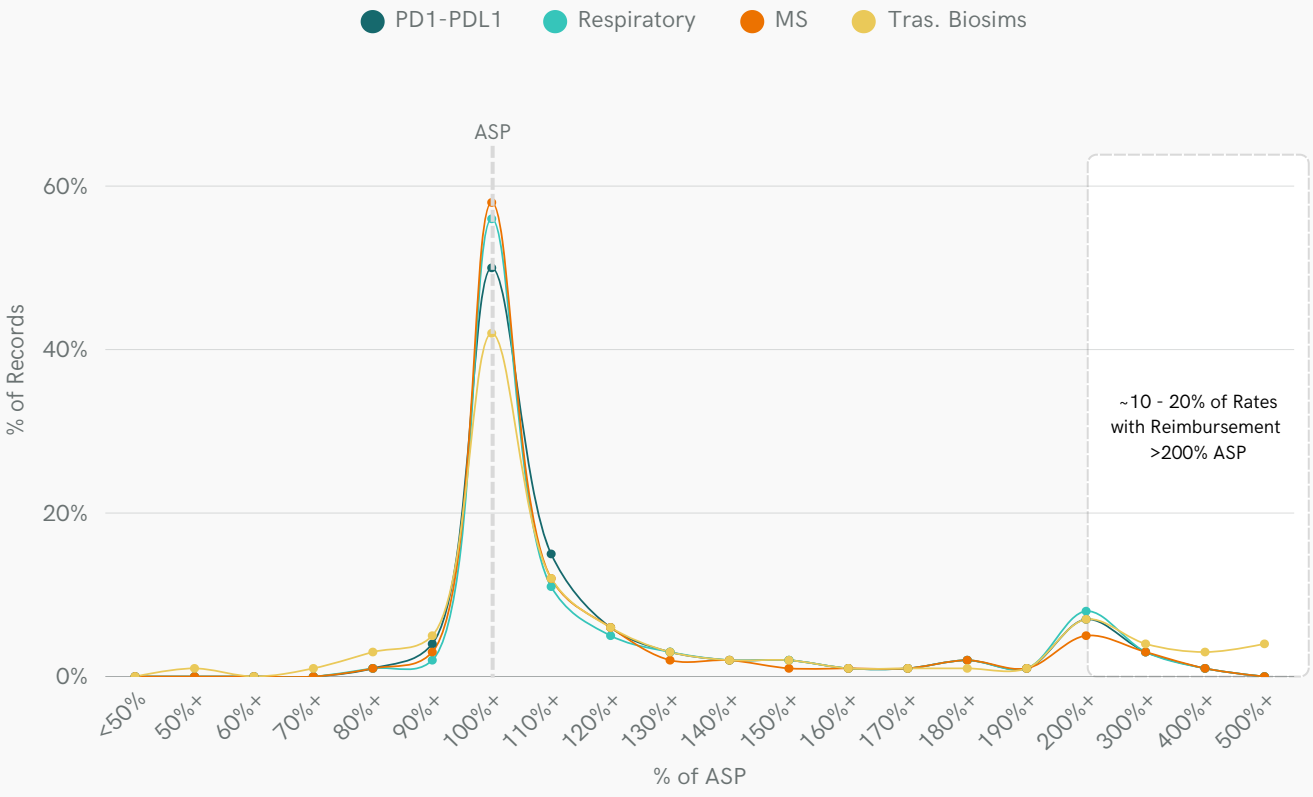


Figure 2

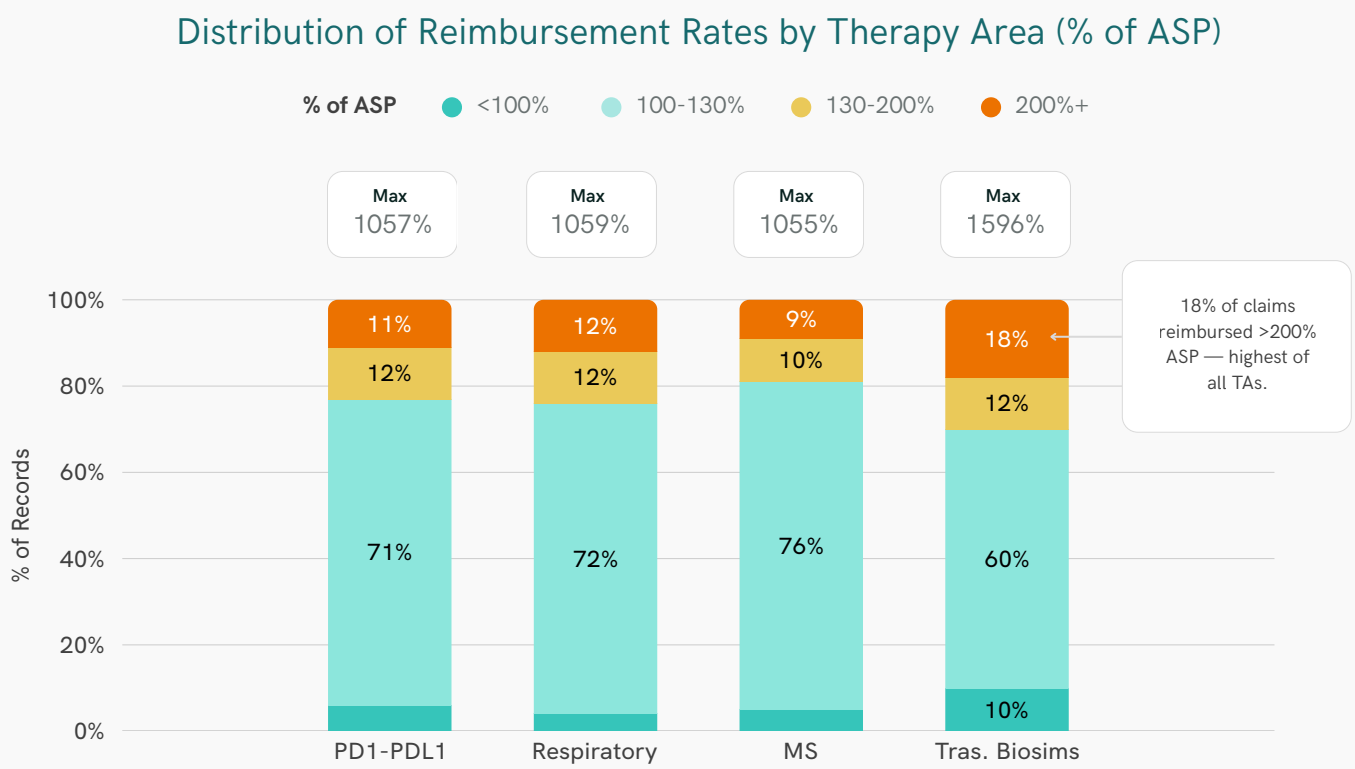


Figure 3

Key Observations

Maximum Reimbursement

All therapy areas show a maximum rate of >10× ASP

Based on our industry expertise, consistency with other reports, and the frequency of these rates in the data, we are confident these are true reflections of reimbursement to providers and not outliers in the data. In many cases, these rates reflect reimbursement from smaller regional payers, or in some cases, from the payer arm of integrated payer-provider networks.

Minimum Reimbursement

~5–10% of reimbursement across TAs is less than ASP

All payer channels had a minimum of ~5% of reimbursement reported as less than ASP, however Medicare Advantage and Managed Medicaid reported below ASP reimbursement more frequently (10-20% of rates).

While we do believe some providers and/or products may be reimbursed less than ASP, the frequency suggested by this data may be slightly overstated as we've observed evidence of delayed reporting in the data.

Biosimilar Dynamics

Trastuzumab biosimilars are ~60% more likely to receive reimbursement >200% of ASP than PD-1/PDL-1s

Trastuzumab biosimilars have the highest concentration of reimbursement >200% of ASP.

This could reflect more differential reimbursement from payers in a less differentiated class of products, or this could be reflecting some portion of biosimilar reimbursement tied to WAC versus ASP.

Commercial vs. Medicare Advantage Reimbursement

Analysis of commercial and Medicare Advantage reimbursement across TAs revealed a consistent theme that commercial payers are likely to reimburse higher and more frequently than Medicare Advantage payers.

Commercial vs. Medicare Advantage Reimbursement Across TAs (% of ASP)

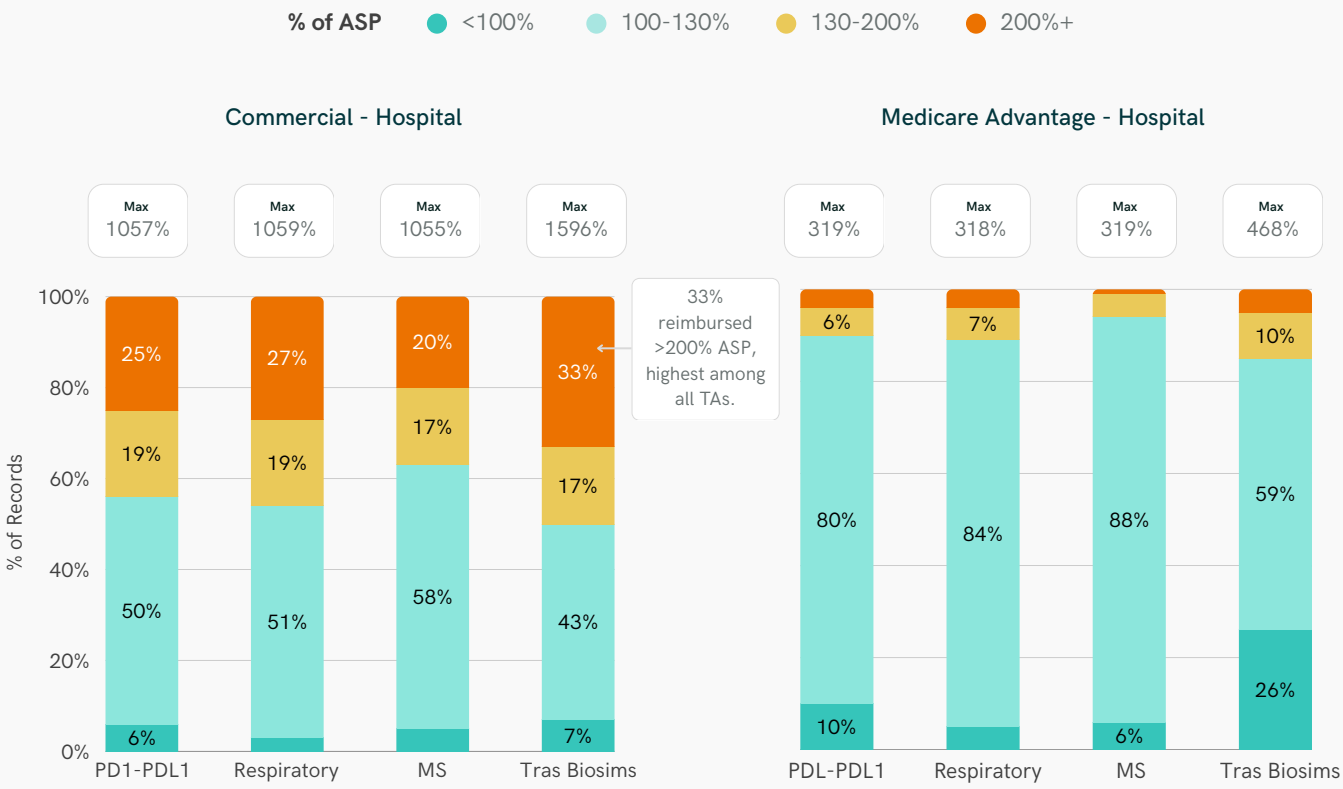


Figure 4

Medicare Advantage Capture: The Transparency in Coverage requirement generally favors capture of commercial data. As written, only hospitals are required to report Medicare Advantage reimbursement, not payers. The current transparency in coverage legislation does not provide any requirements for Medicare Advantage reporting for non-hospital settings, so commercial vs. Medicare Advantage comparisons are restricted to comparisons within the hospital setting. This may change as soon as February 2026, pending the updated v2.0 schema for payer machine-readable files (MRFs). For additional information, see Price Transparency's First EO Comes Due with New Guidance and FAQs about Affordable Care Act Implementation Part 70

Key Observations

Commercial

Commercial reimbursement distributions are largely similar across therapy areas

The similarity in these distributions suggests that commercial reimbursement to hospitals is less determined by market dynamics across TAs and more so by negotiating dynamics between hospitals and payer organizations.

Medicare Advantage

80-90% of Medicare Advantage reimbursement is 100–130% of ASP

Contrary to commercial reimbursement, a vast majority of Medicare Advantage reimbursement is concentrated between 100–130% of ASP (~80-90% of rates). The exception across TAs is trastuzumab biosimilars, for which the data reflects <60% of rates fall between 100–130% of ASP, and >25% of providers are reimbursed below ASP.

Given the wide distribution of ASPs of products in this class (~$3 to $70 per 10mg), this is likely reflecting payers setting a "Maximum Allowable Cost" model for this product basket, which would reimburse the same amount for all Trastuzumab regardless of product used.

Commercial vs. Medicare Advantage

Higher commercial rates may create perverse incentives for providers

Commercial maximum reimbursements are much higher than Medicare Advantage, exceeding ~10× ASP across all therapy areas. Conversely, the highest Medicare Advantage reimbursement caps out closer to ~4.5× ASP. This dynamic may create a disproportionate incentive structure that could ultimately encourage hospitals to prioritize commercial patients over Medicare patients.

Hospitals >6× more likely to receive >200% of ASP for commercial than Medicare Advantage patients

There is a clear disparity between commercial and Medicare Advantage reimbursement to hospitals. Across TAs, Hospitals are >6x more likely to receive reimbursement >200% of ASP for commercial patients than Medicare Advantage patients.

All of the following analyses in this report focus on commercial reimbursement only. The Medicare Advantage data only captures hospital reimbursement, so the focus on commercial reimbursement aims to remove any bias in insights to larger hospital systems. Managed Medicaid data was also excluded from the report due to sample size constraints.

Comparison Across Products

Reimbursement rate distributions look similar at the product level, with more variability in the biosimilars market basket. These reimbursement distributions reflects all *eligible* reimbursement rates, but these analyses are not volume weighted. We would expect more variability if distributions were volume weighted.

Oncology - PD1/PDL1

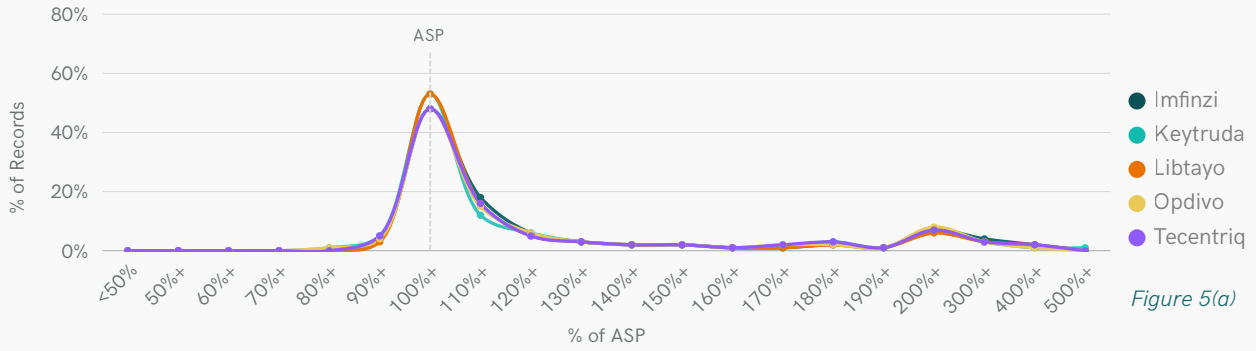


Figure 5(a)

Trastuzumab Biosimilars

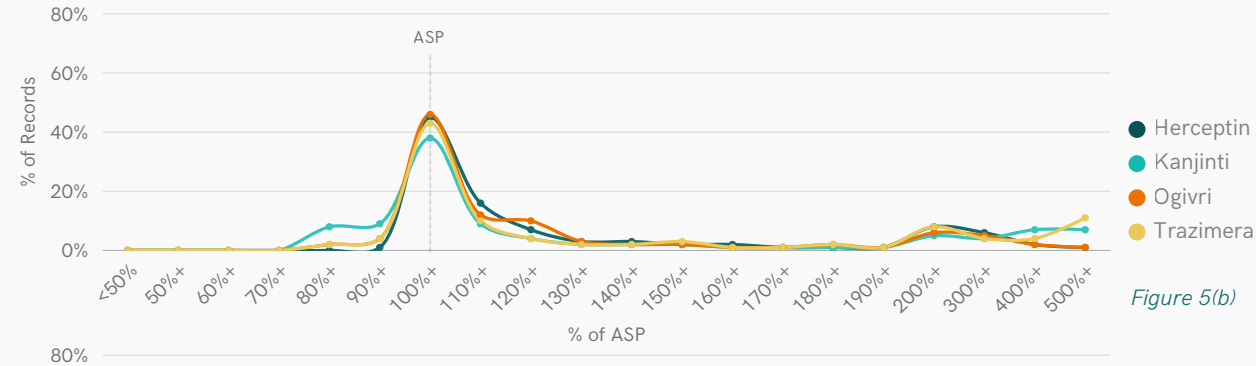


Figure 5(b)

Respiratory

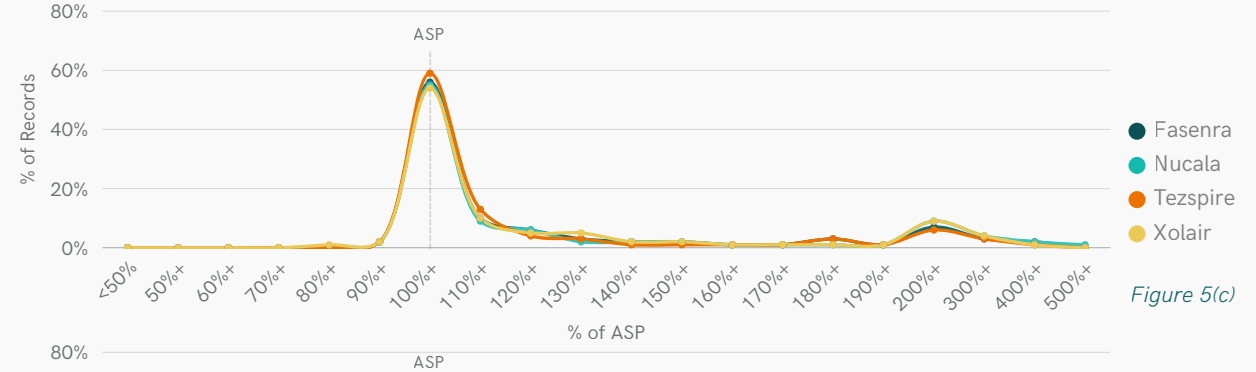


Figure 5(c)

Multiple Sclerosis

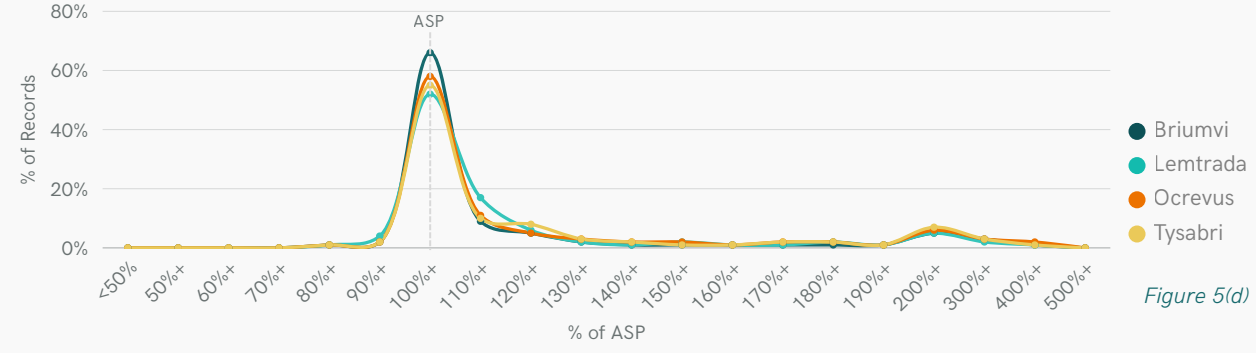


Figure 5(d)

Comparison Across Provider Types

Differential Reimbursement Across Sites of Care

Analysis of commercial reimbursement across sites of care demonstrates a clear trend consistent with conventional understanding of reimbursement dynamics across providers. For the purposes of this analysis, providers were sorted into the following categories:

Hospital

Includes a wide variety of sites affiliated to larger health systems, such as emergency rooms, rehabilitation facilities, hospice centers, and many more. Clinics owned by hospital systems are also captured under this site of care.

Alternate Sites of Care (ASOC)

Primarily includes infusion centers, ambulatory surgery centers, and home infusion companies.

Other

Includes specialty pharmacies and a variety of standalone sites not affiliated to larger health systems, such as psychiatric units, independent labs, imaging centers, and many more. These sites may rarely buy and bill products but have an eligible rate present in the data.

Speciality Group

Primarily includes outpatient facilities with a specific specialty focus. While business rules were used to identify these providers, they predominantly include the traditional "clinic" setting.

Commercial Reimbursement by Site of Care Across TAs (% of ASP)

Figure 6

Key Observations

Relative Reimbursement Across Sites of Care

Hospitals have the highest overall average reimbursement, followed by ASOC, Other, and Specialty Groups

Hospitals are ~3× as likely as specialty groups to receive reimbursement >200% of ASP, ASOC are ~2× as likely. Beyond sites of care, these insights are largely correlated to the size of providers mapped to each segment. Specialty groups or clinics affiliated to hospitals were mapped to the hospital site of care, so we can largely assume specialty groups as defined in this analysis are smaller, independent sites with less negotiating power with payers.

Absolute Reimbursement Across Sites of Care

Hospitals receive reimbursement >200% more frequently, but when providers received reimbursement >200% of ASP, absolute reimbursement rates >200% ASP were similar across sites of care

When we compared the rates >200% of ASP across sites of care, we found similar means and medians. We can conclude that while hospitals and ASOC are *more likely* to receive reimbursement >200% of ASP, absolute reimbursement rates above 200% of ASP across sites of care are likely to be similar.

Breaking Down Reimbursement Methodology

The reimbursement data includes some insight into the the "method" by which reimbursement is determined, and is generally captured in one of four categories. These categories may not be reliably or consistently reported, so we take these insights directionally. This is an area we will continue to track and monitor over time, as we expect reporting requirements to be clarified and adherence to improve over time, which will enrich the insights that can be extracted through this field.

Fee Schedule

A predetermined list of standardized rates that payers will reimburse for specific products, irrespective of the billed amount by the provider. These rates are 1) Typically indexed to a public product price (WAC/AWP, ASP, AMP), and 2) The default rates providers are eligible for unless they've specifically negotiated a rate that falls under any of the categories listed here.

Percent of Charges

A model in which payers and providers negotiate a percentage basis that payers will reimburse based on what providers will bill the payer (referred to as gross charge or billed amount). This model typically leads to the highest reimbursements, as providers have discretion to mark up the billed amount above the cost of treatment while the percentage remains somewhat static during the course of the contract between the payer and provider.

Negotiated (Only Applies to Payer MRFs)

An indicator that a provider has negotiated a specific rate with a payer. Unfortunately, current Transparency in Coverage legislation does not require additional details to be provided on the nature of the negotiation. While this field is helpful to distinguish from "fee schedule," on its own, it does not provide much insight into the reimbursement basis for providers. This could potentially change with the introduction of the v2 schema for Transparency in Coverage files.

Other

Other reimbursement rates reflect a variety of other less-traditional reimbursement methods including capitated, per diem, value-based, and bundled payment models.

Reimbursement Methodology Summary across TAs

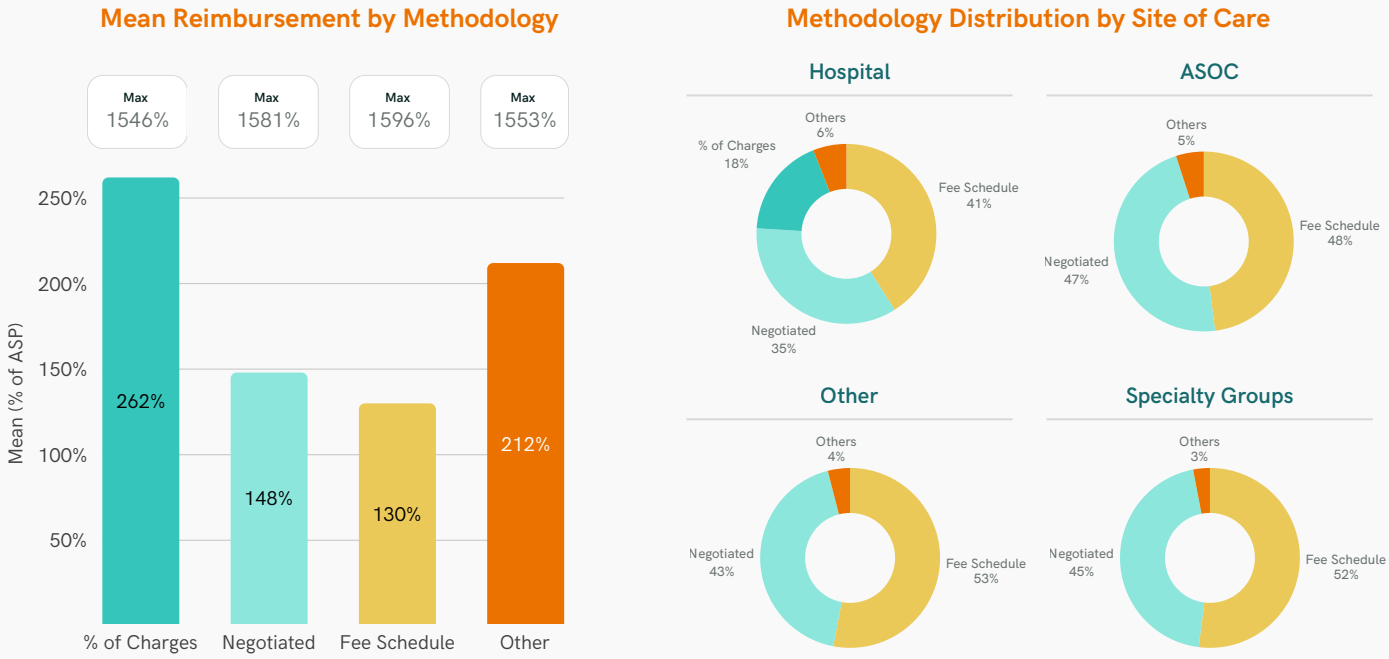


Figure 7

Key Observations

Percent of Charges

Percent of charges reimbursement is >2x fee schedule reimbursement, on average

Figure 7 shows the average reimbursement premium across all products and TAs evaluated by each reimbursement methodology. Percent of charges shows the highest premium to ASP and is only present in the hospital site of care, which may not be surprising as we generally expect large hospital systems to have more negotiating power with payers.

Maximum Reimbursements

All methods show similar maximum rates

Similar maximum rates across methodologies suggests that while some methodologies may have tendencies to result in higher or lower rates, each methodology **can** result in high or very reimbursement to providers.

Reliability of "Reimbursement Methodology" Reporting

Beyond these directional insights, we caution reading too much into these methodologies

Reporting requirements for reimbursement methodology are vague and outputs may be more reflective of inconsistent reporting rather than true insight. As this continues to be an area of interest, we will report on this field for any indicators of improved quality or consistency.

Highest Reimbursed Providers

We believe the most exciting and promising use case for price transparency data are its potential to change a patient's everyday interactions with healthcare. The following section imagines what the future of "shopability" in healthcare might look like: A world where patients could compare costs across providers before receiving care by examining reimbursement variances at the individual provider level.

The following analysis looked at a subset of providers who had >50% of their eligible reimbursement exceed 200% of ASP. It is meant to illustrate the grain of insight that can be extracted from the data, and the potential to help patients make more-informed healthcare decisions.

Key Observations

Rates Exceeding 200% of ASP

High rates above 200% ASP are common, not outliers

Providers included in this analysis typically received >200% ASP reimbursement for 50-70% of their patients, suggesting these high rates are not outliers, but common across payers. At least one provider in the respiratory market was identified as having 100% of their commercial reimbursement exceeding 200% of ASP.

Maximum Reimbursement by Product[3]

Reimbursement of 3-5x ASP is common in large health systems

Maximum product reimbursement between 3-5× ASP is observed across all therapy areas. Some maximum reimbursements of >10× ASP are observed for biosimilar products, though this is largely driven by the very low ASPs of Trazimera and Kanjinti.

Differential Reimbursement by Payer

Payers may use reimbursement as a form of utilization management

In some instances, the same payer was responsible for the maximum reimbursement across all products for a given provider. These differential premiums provide some evidence that payers may use reimbursement as a mechanism to steer utilization of some products over others.

Economic Implications for Providers

Reimbursement differences across products create real economic implications for providers

We see a wide range of maximum reimbursements across products, from ~<5% difference to >600% difference. While in some cases these maximum reimbursement rates may be provided by different payers and therefore don't fully represent an apples-to-apples comparison, the magnitude of these deltas illustrates the significance of the economic implications facing providers when making treatment or institutional formulary decisions. For a high-cost specialty product, the difference of just 25% in reimbursement premium can have implications of >$50,000 per patient per year.

3. For the purposes of this analysis, we removed reimbursements from integrated payer-provider systems, which often reflected reimbursements of >10x of ASP across products in all therapy areas. Non-dollarized, percentage-based rates have been excluded. The provider's name reflects top parent entities where available. **All rates shown as a percentage of product-specific ASP.**

Oncology - PD1/PDL1

Figure 8(a)

Maximum Reimbursement By Product % of ASP

Provider	% Rates > 200% of ASP	Min Reimbursement	Median Reimbursement	Imfinzi	Keytruda	Libtayo	Opdivo	Tecentriq
Large health system in TX	77%	111%	238%	412%	357%	361%	413%	393%
Academic center in IN	76%	103%	226%	340%	330%	364%	326%	340%
Children's hospital in OH	75%	96%	314%	390%	345%	376%	358%	368%
Academic center in S CA	66%	95%	212%	224%	222%	237%	321%	331%
Community hospital in NY	62%	86%	212%	219%	420%	212%	360%	412%
Academic center in OH	60%	85%	218%	246%	246%	246%	341%	246%
Regional hospital in CO	58%	112%	242%	318%	397%	312%	409%	341%
Academic center in N CA 1	53%	102%	209%	400%	382%	400%	390%	397%
Academic center in N CA 1	52%	93%	225%	495%	489%	523%	493%	515%
Community hospital in WA	51%	100%	202%	384%	395%	375%	391%	379%

Trastuzumab Biosimilars

Figure 8(b)

Maximum Reimbursement By Product % of ASP

Provider	% Rates > 200% of ASP	Min Reimbursement	Median Reimbursement	Ogivri	Trazimera	Herceptin	Kanjinti
Regional health system in WI	70%	85%	250%	428%	1065%	438%	767%
Academic center in MA 1	67%	106%	224%	360%	501%	334%	649%
Community hospital in NY	62%	91%	212%	212%	503%	359%	335%
Academic center in MA 2	60%	92%	216%	244%	627%	280%	1208%
Large health system in NC	58%	89%	236%	373%	542%	376%	466%
Academic center in OH	53%	106%	226%	330%	246%	403%	436%
Children's hospital in OH	52%	106%	212%	399%	360%	420%	360%
Regional hospital in PA	51%	90%	207%	380%	904%	345%	1025%
Community hospital in TX	50%	140%	286%	177%	570%	140%	395%
Academic center in NY	50%	106%	205%	212%	537%	199%	419%

Respiratory

Figure 8(c)

Maximum Reimbursement By Product % of ASP

Provider	% Rates > 200% of ASP	Min Reimbursement	Median Reimbursement	Xolair	Fasenra	Tezspire	Nucala
Academic center in CT	100%	264%	301%	419%	379%	373%	364%
Children's hospital in MA	95%	107%	388%	517%	486%	107%	422%
Community hospital in CT	88%	141%	236%	288%	246%	256%	250%
Community hospital in NY	70%	91%	229%	298%	417%	212%	421%
Academic center in OH	69%	100%	232%	357%	367%	585%	350%
Academic center in CA	62%	95%	220%	337%	221%	242%	331%
Community hospital in NY	58%	89%	211%	298%	293%	212%	295%
Academic center in MA 1	56%	87%	214%	505%	350%	372%	308%
Academic center in MA 2	56%	98%	214%	379%	415%	453%	368%
Children's hospital in CA	55%	107%	225%	321%	329%	329%	327%

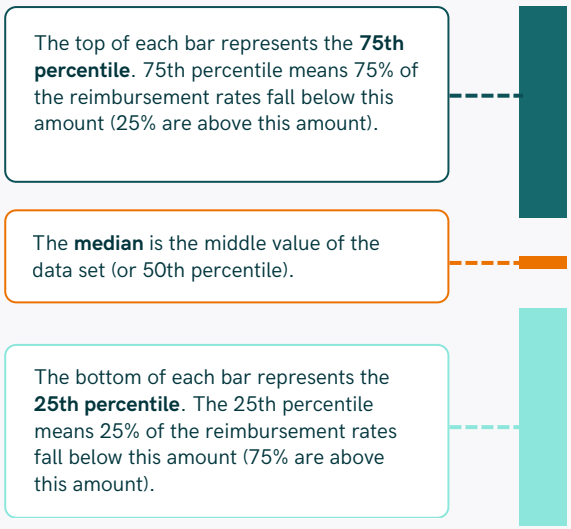
Multiple Sclerosis

Figure 8(d)

Maximum Reimbursement By Product % of ASP

Provider	% Rates > 200% of ASP	Min Reimbursement	Median Reimbursement	Tysabri	Ocrevus	Lemtrada	Briumvi
Academic center in CT	80%	105%	289%	419%	300%	301%	299%
Academic center in IN	69%	105%	212%	341%	356%	341%	289%
Academic center in OH	67%	93%	322%	421%	381%	387%	360%
Academic center in FL	63%	113%	211%	376%	344%	334%	310%
Regional hospital in IN	57%	105%	238%	805%	750%	752%	749%
Academic center in MA	56%	105%	210%	361%	244%	244%	244%
Academic center in OH	56%	103%	218%	412%	292%	245%	244%
Children's hospital in CA	55%	107%	225%	361%	321%	327%	327%
Academic center in CA	52%	95%	209%	343%	248%	233%	227%
Academic center in NY	50%	88%	160%	213%	210%	211%	210%

Comparison Across Payer Segments



Interpreting Box and Whisker Plots

The following sections will investigate reimbursement distributions across sites of care and payers. Given the analysis is comparing multiple distributions, data has been represented in a "box and whisker" plot.

A note on interpreting these charts:

- For the following charts, the "whiskers," or min and max ranges, have been removed due to large outliers disrupting the scale of the chart. The min and max values have been provided in tables. In addition, we've set the minimum y-axis value to "100% of ASP".

High and Ultra-High Reimbursement Rates

All data summaries in **Figure 9** show a strong positive skew, meaning the median and 25th percentiles are close together while the 75th percentile is further apart. In the following analysis, **the further the distance between median and 75th percentiles, the higher the presence of high and ultra-high reimbursement rates.**

Figure 9(a)

Trastuzumab Biosimilars

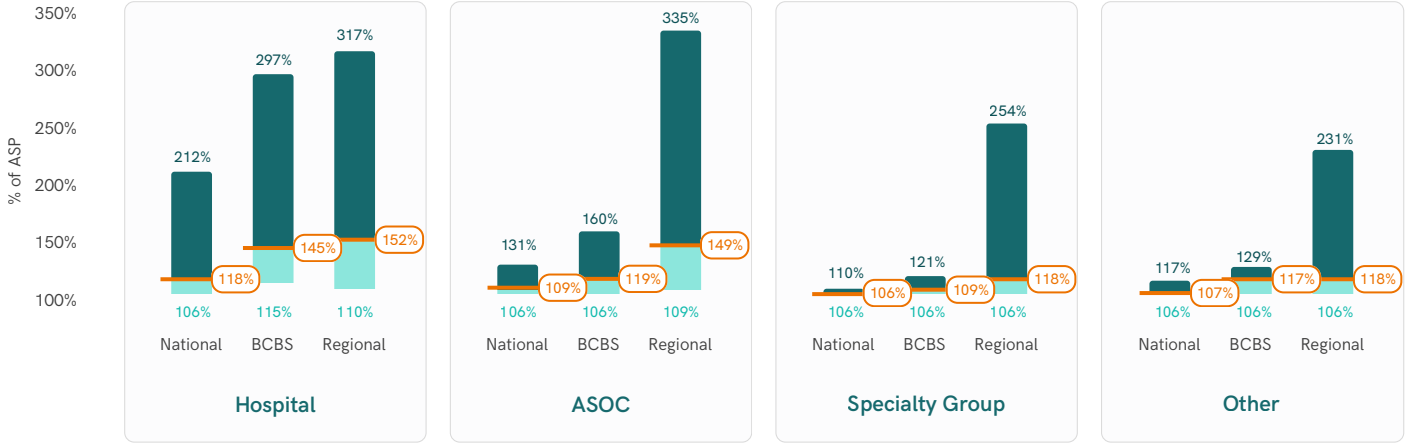


Figure 9(b)

Respiratory

Figure 9(c)

Multiple Sclerosis

Figure 9(d)

Key Observations

Minimum and Maximum Reimbursement

Minimum and maximum commercial rates are similar across all TAs, when measured as a percentage of ASP

Minimum reimbursements look similar across TAs, though this may be explained by business rules to "scrub" ultra-low reimbursement rates. Maximum reimbursements largely look similar, although trastuzumab biosimilars appear to have a maximum of ~15× ASP compared to other TAs which have maximums of closer to 10-12× ASP.

Median Reimbursement

Median rates are highest for regional payers, and lowest for national payers

Median reimbursements also look similar across TAs, with a consistent trend of national payers having the lowest median reimbursement, followed by BCBS, then regional plans. This pattern is consistent across all sites of care.

Median reimbursements are also consistently significantly closer to the 25th percentile versus the 75th percentile reimbursement, indicating a long tail of high/ultra-high reimbursements across all payers, TAs, and sites of care.

Range of Reimbursement

National and BCBS payers consistently show a wider range of reimbursement with hospitals, illustrating the negotiating power hospitals have, even with large national payers

Regional payers, however, show a wide range of reimbursement across all sites of care. This reflects the relatively lower negotiating power of regional payers relative to providers across different geographies, and it also explains the proliferation of "Medical Benefit Managers" that aim to improve the collective bargaining power of regional plans to control increasing medical benefit costs.

Biosimilar Dynamics

The Trastuzumab biosimilar market basket exposes a few unique insights that differ from the other three market baskets

National payer reimbursement for biosimilars is similar to other TAs, however, regional and BCBS payers show a wider range of reimbursement. A few potential explanations for these dynamics include:

- **Potential "MACing of the Class":** For the purposes of comparing across products and classes, rates have been normalized to an ASP basis, however, it may not be defined/negotiated on this basis with providers. Given the dynamic nature of biosimilar ASPs, regional payers may be more likely to "MAC the Class," meaning providing the same dollar reimbursement on all trastuzumab volume. Given significant variance in ASPs in the basket ($3 to $70 per 10mg), this dynamic would necessarily show more reimbursement variability on an ASP basis.
- **Provider Advocacy:** As ASPs have eroded in this class, some by up to 90%, it has likely become unsustainable for manufacturers to maintain a purchase price below ASP. In these instances, providers may advocate with payers to increase reimbursement. While this may be challenging with national payers, regional payers may be more open to reimbursement increases to keep providers above water. For payers, slightly increased reimbursement for smaller specialty groups may very well be the preferred alternative to those groups referring patients out to higher-cost sites of care.

Median BCBS Reimbursement by State

BlueCross BlueShield (BCBS) plans were carved out as an independent cohort to evaluate whether reimbursement reflected negotiating power more similar to national payers or more similar to independent regional plans. At a national level, across TAs and sites of care, BCBS plans arguably mirror national payers more closely than regional payers. However, there is significant variation in BCBS reimbursement at the state level.

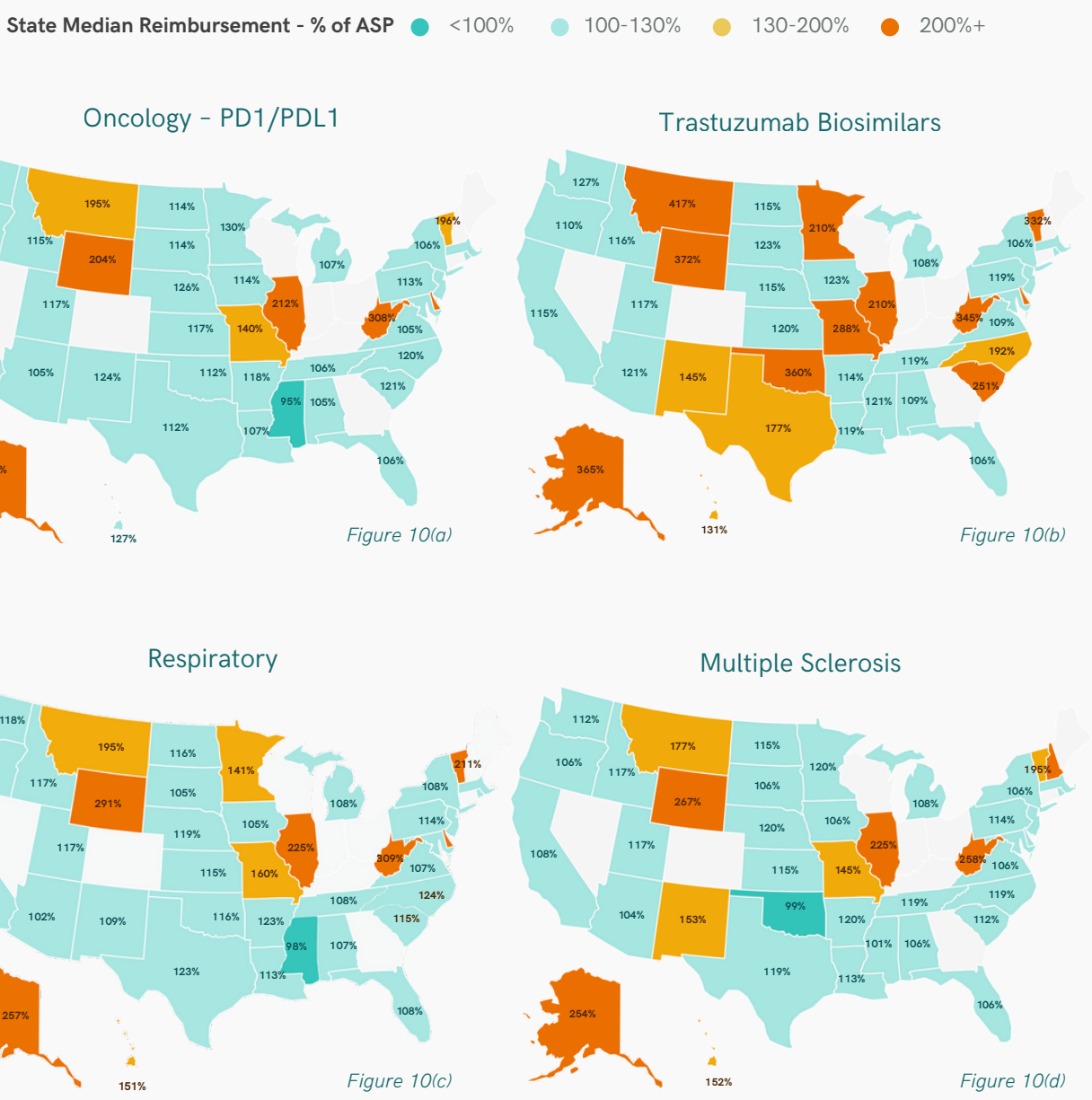


Figure 10(a)

Figure 10(b)

Figure 10(c)

Figure 10(d)

Comparison Across National Payers

Reimbursement from national payers was ranked for each payer based on their median reimbursement and reimbursement range across sites of care. Lower numbers reflect a lower median and less variable reimbursement, and may imply less willingness to negotiate unique reimbursement rates with providers.

Payer Rankings: Reimbursement Median and Variability by Site of Care

Higher Rank reflects higher median reimbursement and more variability; **Lower Rank** reflects lower median and less variability

Median Reimbursement Rank by Provider Type	Anthem	Cigna	United	Aetna
Hospital	1	3	2	4
ASOC	1	4	2	3
Other	2	1	4	3
Specialty Group	2	1	4	3
Overall Rank	1	2	3	4

Figure 11

Anthem reimburses the lowest overall with the least variability across providers

Anthem has the most uniform reimbursement across non-hospital sites; it illustrates the least willingness to reimburse differentially across provider types.

Cigna reimburses lowest to specialty groups, highest to ASOC

Cigna is unique in reimbursement to ASOC; in some cases it reimburses higher to ASOC than to hospitals.

United reimburses highest to specialty groups; second-highest overall

United has the second-lowest median reimbursement to hospitals; a lower 75th quartile suggests less exposure to "very high" hospital reimbursement compared to Aetna and Cigna.

Aetna reimburses highest overall with the most variability in hospitals

Aetna has the highest median reimbursement and the highest 75th quartile in hospitals, suggesting more exposure to "very high" hospital reimbursement than other national payers.

Hospital

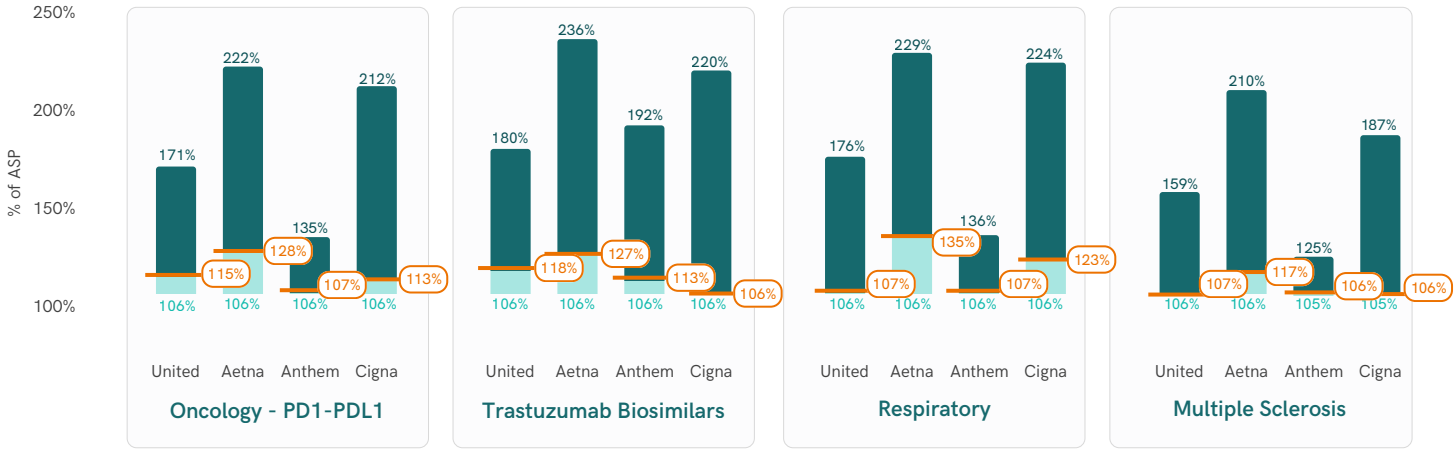


Figure 12(a)

ASOC

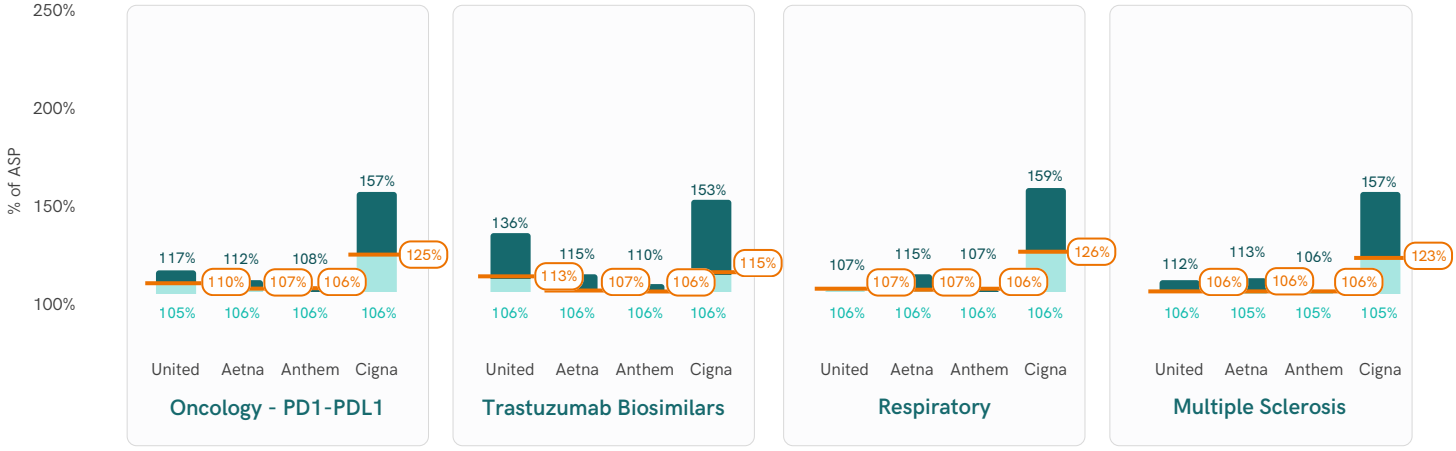


Figure 12(b)

Specialty Group[4]

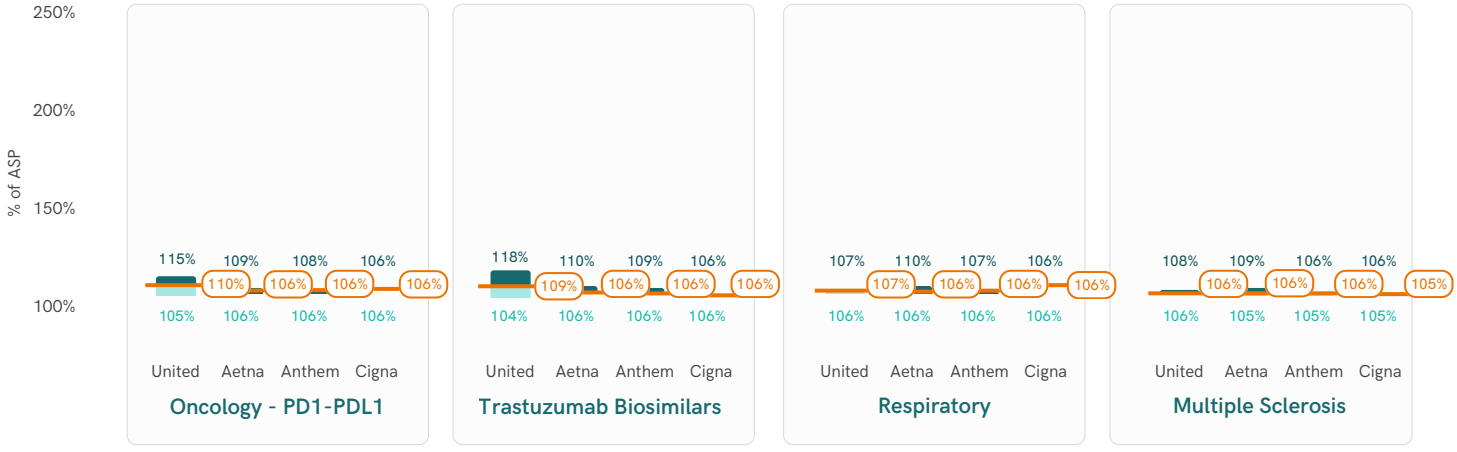


Figure 12(c)

4. Providers categorized as "Other" were excluded from this chart as this provider type shows similar trends as providers categorized as "Specialty Group"

Commentary

Implications on Patient Access

Price transparency data facilitates more targeted interventions to maximize patient access
The growing availability of price transparency data represents a potential paradigm shift for patients and pharmaceutical manufacturers. Historically, manufacturers had limited visibility into how their products and competitors were reimbursed across geographies, payers, and provider settings. Now manufacturers can gain insights into real-world reimbursement dynamics and the implications on patient access at the provider level.

Near-Term Predictions

Legislative tailwinds signal continued emphasis on price transparency in the U.S.
Looking ahead, several legislative developments may further enhance the utility of drug price transparency data under ongoing price transparency efforts by the current administration. Price transparency has a history of bipartisan support, and the current administration has already released several executive orders in 2025 that signal continued evolution and enforcement of existing legislation.

Enforcement of prescription drug reimbursement transparency is on the horizon
This prescription drug reimbursement reporting was initially slated for enforcement in July 2022, but was paused due to operational constraints. The current administration has indicated a renewed interest in enforcing reporting for this broader set of products and services, and recently issued an RFI focused on expanding and refining drug price transparency reporting requirements[5]. We interpret these signals as an indicator that additional enforcement and oversight is likely to be on the horizon.

Longer-Term Predictions

Price transparency will facilitate more competition and decrease the cost of healthcare in the U.S.
Payers, providers, and pharmaceutical manufacturers are beginning to unlock the power of price transparency data to inform key business decisions, including how they approach pricing and reimbursement negotiations with each other. With continued enforcement of price transparent legislation, the data will continue to become richer, more robust, and more mature, and should lead to overall downward pressure on healthcare costs.

It is our belief that this transparency is the greatest mechanism we have to increase competition, remove middle-men, and lower the cost of healthcare in the U.S. We still have work to do to achieve shopability at scale, but we are thrilled to see the possibility is beginning to come into focus.

5. Read Turquoise Heath's public comment on this RFI (link).

About Turquoise Health

Turquoise Health is the industry's leading price transparency platform. Through its data, contracting, and compliance products, Turquoise is making healthcare prices astonishingly simple for patients, providers, payers, employers, life sciences, and the government.

Learn more at www.turquoise.health

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Want to view the underlying data used in the report?

Contact Us

About ZS

ZS is a management consulting and technology firm that partners with companies to improve life and how we live it. We transform ideas into impact by bringing together data, science, technology and human ingenuity to deliver better outcomes for all. Founded in 1983, ZS has more than 13,000 employees in over 35 offices worldwide.

As experts in life sciences value and access, ZS maximizes patient benefit and value realized by designing and implementing access strategies globally and locally. We help companies collaboratively create and implement market access strategies, pricing and value communication with our deep industry knowledge and data-driven insights. Our mission is to help companies plan for local implementation and world-class execution while transforming the organization. Because realizing and creating value matters.

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About the Data

Sources & Scope

Price transparency data is sourced from hospitals and payers. Hospitals and payers are mandated to publish their pricing information on their public domains in the form of Machine Readable Files (MRFs) as part of two CMS regulations: The Hospital Price Transparency Final Rule and the Transparency in Coverage Final Rule (TiC).

Hospital Price Transparency Final Rule

The Hospital Price Transparency Final Rule was issued by the Centers for Medicare and Medicaid Services (CMS). The rule was finalized in November 2019 and became effective in January 2021. The rule requires U.S. hospitals to publicly disclose their pricing information across services and procedures captured in their chargemaster (CDM)

Coverage & Compliance: Since its implementation, there have been additional efforts to increase usability of the data by standardizing the schema and mandating fields that target drug reporting. Today, nearly two billion rates are collected from over 6,000 hospitals belonging to 650 health systems in the U.S. (about 97%). This value continues to increase over time as more hospitals are becoming compliant.

In July 2024, recent requirements for hospital machine-readable files (MRF) went into effect, which mandated the disclosure of contracting methodology, unit of measurement for drugs, and additional fields to increase robustness and usability of the data. As of January 2025, these files are increasingly used by various stakeholders in the healthcare ecosystem for their decision-making processes.

Transparency in Coverage Final Rule (TiC)

TiC was jointly issued by the Department of Health and Human Services, Labor and Treasury. The ruling was published in October 2020, then implemented in July 2022. The rule imposes similar transparency requirements on payers. It mandates the public release of monthly machine-readable files containing in-network and out-of-network negotiated rates across all their sites of care. However, only commercial rates were mandated by the ruling.

As part of Trump's recent executive orders for increased price transparency, Requests for Information (RFIs) have been issued to include Prescription Drug File and Managed Medicaid/Medicare Advantage rates by payers.

Coverage & Compliance: Over 250 payers are publishing MRFs every month, accounting for >90% of covered commercial lives. Payers publish rates across all sites of care, including 6,000 hospitals, 13,000 ambulatory surgical centers, and 14,000 infusion centers.

Required Info	Hospital Price Transparency Final Rule	Transparency in Coverage Final Rule
Pricing	Gross charges, cash prices, negotiated rates	Negotiated rates
Payer Channels	Commercial, Managed Medicaid, Medicare Advantage	Commercial; others are optional
Sites of Care	Hospital	All
Refresh	At least annually	Monthly

Turquoise Health Price Transparency Data

Machine-readable files (MRF) published by hospitals are payers are publicly available, but there are significant barriers to their use. These large, messy datasets often contain duplicates and lack dosage standardization. On top of this, price transparency data is published by two very different regulatory-mandated sources (payers and hospitals), each with different data schemas. Despite the availability of these files, significant data storage, engineering, and revenue cycle expertise is required to extracting meaningful insights. Since 2021, Turquoise Health has worked tirelessly to gather, clean, and enrich this data for industry and consumer use.

The data used in this report is not weighted by utilization nor does it account for a payer's utilization management. We believe the value of price transparency data is highest when it's married to claims data and payer policy data, as it provides a more holistic view on the drivers or barriers of uptake at the payer and provider level.

About Drug Primary Rates

Drug Primary Rates are a comprehensive aggregation of data from both hospital and payer data. Using proprietary methodology, Turquoise Health tiers, ranks, and standardizes the rates to ensure reliability and clarity. This acts as a robust data foundation for both our platform ad-hoc analysis. Methodologies, business rules, and assumptions used to transform the data include:

- Data pulled from two major data sources: Hospital Price Transparency and Payer Transparency in Coverage
- Rates aggregated from these data sources to a single rate per payer per provider, adjusted to HCPCS billing unit
- Leverages the most prevalent rate across data sources for a given payer/provider/code, which we define as "the rate worth caring about"
  - As a part of this selection, machine learning is used for outlier detection
  - The charge description, NDC, and unit of measure is used to arrive at dose standardized rates adjusted to HCPCS billing unit
  - If rates appear as percentage for hospitals, the percentage is multiplied with the gross charge to arrive at the negotiated rate
  - If multiple rates appear for payer/provider combo, a rate is selected based on plan product tiering logic
  - Data comes in at the NPI individual level and is consolidated to the organization level by leveraging affiliations/hierarchy files
- Output into the final "Drug Primary Rates" tables[6] is refreshed monthly

Drug Primary Rates is refreshed on a monthly basis so users always have access to both the latest and greatest rates and historical rates. Additionally, it's been integrated into Turquoise Health's life-sciences-specific products so users can enjoy a one-stop solution to navigate to their desired rates.

Additional Data Transformations

ASP Calculation

The Centers for Medicare and Medicaid Services (CMS) typically sets the Medicare Part B payment limit at 106% of the ASP. To derive the Average Sales Price (ASP) from the available payment limit, the payment limit was divided by 1.06.

ASP Payment Limit Lag Adjustment

Reimbursement data ingested on 10/1/2024 was assumed to reflect Q3'24 reimbursement rates, and was therefore normalized to Q3 2024 ASPs. To further account for potential lag in reported reimbursement, we searched for reimbursement rates that exactly matched ASP payment limits from Q1'24 and Q2'24. We identified ~1% of rates that met this criteria, suggesting a two- to three-quarter lag in reporting.

Rate Inclusion

Some reimbursement rates are submitted as percentages or in formats that cannot be dollarized due to the absence of associated charge data. While these rates are counted in the contract methodology-level summary (**Figure 7**) for completeness, they are excluded from reimbursement distribution summaries as there is no reliable way to convert these rates into dollar values. Within this analysis we have been able to dollarize ~80% to 90% of percent of charge reimbursement rates.

Negotiation Type Categorization

The following rules were applied to map "contract methodology" as reported in the data to "negotiation type": Negotiated = "Negotiated"; percent of total billed charges, percentage = "Percent of Charges"; Fee Schedule = "Fee Schedule"; case rate, derived, per diem, other, any unrecognized or null value = "Others"

Payer Classification

To ensure consistent categorization and comparison of payers across TAs, payers were categorized based on the affiliation and market presence rules below. During this process, we identified a payer labeled "HealthSmart" that exhibited an unusually strong skew in its rate pattern for Multiple Sclerosis and appeared as an outlier, so it was excluded from the analysis.

National Payers

National-level insurance providers were identified based on their extensive presence across multiple states and were grouped into the "National" payer category. These payers include United Healthcare, Anthem, Aetna, and Cigna.

BCBS Payers

All payers affiliated with the Blue Cross Blue Shield (BCBS) Association were identified and grouped in the "BCBS" payer category. BCBS payers include the following 37 commercial payers (offering ~800 commercial plans).

Blue Cross Blue Shield of Alabama, Blue Cross Blue Shield of Arizona, Blue Cross Blue Shield of Arkansas, Blue Cross Blue Shield of Florida (Florida Blue), Blue Cross Blue Shield of Hawaii (HMSA), Blue Cross Blue Shield of Illinois, Blue Cross Blue Shield of Kansas, Blue Cross Blue Shield of Kansas City, Blue Cross Blue Shield of Louisiana, Blue Cross Blue Shield of Maryland & DC (CareFirst), Blue Cross Blue Shield of Massachusetts, Blue Cross Blue Shield of Michigan, Blue Cross Blue Shield of Minnesota, Blue Cross Blue Shield of Mississippi, Blue Cross Blue Shield of Montana, Blue Cross Blue Shield of Nebraska, Blue Cross Blue Shield of New Jersey (Horizon), Blue Cross Blue Shield of New Mexico, Blue Cross Blue Shield of New York (Excellus), Blue Cross Blue Shield of North Carolina, Blue Cross Blue Shield of North Dakota, Blue Cross Blue Shield of Oklahoma, Blue Cross Blue Shield of Pennsylvania (Capital Blue Cross), Blue Cross Blue Shield of Pennsylvania (Independence), Blue Cross Blue Shield of Puerto Rico (Triple-S), Blue Cross Blue Shield of Rhode Island, Blue Cross Blue Shield of South Carolina, Blue Cross Blue Shield of Tennessee, Blue Cross Blue Shield of Texas, Blue Cross Blue Shield of Vermont, Blue Cross Blue Shield of Wyoming, Blue Shield of California, Blue Cross of Idaho, Highmark Blue Cross Blue Shield, Premera Blue Cross, Regence Blue Cross Blue Shield, Wellmark Blue Cross Blue Shield.

Regional Payers

All remaining payers that do not fall under the BCBS or National categories are classified as "Regional" payers. These typically operate within limited geographic regions or serve specific populations. This segmentation framework ensures consistency in payer classification and supports comparative analysis across payer types.

Provider Classification

To ensure consistent categorization of providers across TAs, providers were classified using below rules applied to the Drug Primary Rates (DPR) and Demographics files.

- **Hospital:** Providers listed as "Hospital" in the provider type column of the DPR extract were classified as hospitals.
- **Specialty Group:** Providers listed Neurology Group, Ophthalmology Group, Immunotherapy Group and Rheumatology Group, Physician Groups, Clinics, Ophthalmology, Internal Medicine, Psychiatry, Allergy and Immunology, Urology, Dermatology, Obstetrics and Gynecology, which were classified as specialty groups.
- **ASOC (Alternate Sites of Care):** Includes home infusion, ambulatory surgical centers, and infusion centers.
- **Others:** "Others" and "Specialty Pharmacies" provider types from the Drug Primary Rates data were classified under this category.

Provider Parent Identification

The provider's hierarchy and affiliations were considered to determine the provider parent name:

- Parent Identification: In the hierarchy/ affiliations file, the provider name field reflects the top parent entity. This consolidates affiliated entities under a single recognizable parent/organization name.
- Standalone Entities: In cases where the provider field/parent entity was not listed or unavailable in the affiliations file, the individual child entity was retained and considered as the parent/organization.

Identification of Top Providers by Therapy Area

To determine the top providers within each therapy area (TA), the following steps were followed:

- Step 1: Check for # Records – Providers must have minimum 150 records for the respective TA
- Step 2: High Reimbursement Concentration – From the list of providers identified in Step 1, providers with at least 50% of their records in the "Very High Reimbursement" bucket, defined as ≥ 200% of ASP, are considered for Step 3
- Step 3: Select the top 10 providers from the providers identified in Step 2 based on: (1) higher number of records, and (2) higher commercial dollarized reimbursement rates received from payers, excluding IPPNs and Kaiser

Scope of Data *Ingest Date: Oct - Dec 2024*	Immunotherapy: Oncology	Respiratory	Multiple Sclerosis	Trastuzumab Biosimilars
# Products	5	4	4	4
# Records	891,421	695,363	735,755	617,544
# Unique NPIs	55,223	55,734	57,921	55,251
# Providers	32,332	32,749	33,778	32,390
# Records by Provider types	891,421	695,363	735,755	617,544
• Hospital	419,868 | 47%	320,630 | 46%	310,560 | 42%	285,348 | 46%
• Ophthalmology Group	120,201 | 13%	95,096 | 14%	108,050 | 15%	84,536 | 14%
• Infusion Center	107,886 | 12%	85,851 | 12%	97,203 | 13%	74,952 | 12%
• Neurology Group	79,349 | 9%	63,786 | 9%	72,121 | 10%	57,073 | 9%
• Other	63,848 | 7%	50,716 | 7%	57,030 | 8%	46,107 | 7%
• Immunotherapy Group	44,522 | 5%	36,939 | 5%	39,862 | 5%	30,691 | 5%
• Ambulatory Surgery Center	42,001 | 5%	31,371 | 5%	37,475 | 5%	29,105 | 5%
• Home Infusion	9,848 | 1%	7,859 | 1%	10,052 | 1%	6,895 | 1%
• Specialty Pharmacy	2,353 | <1%	1,881 | <1%	2,055 | <1%	1,762 | <1%
• Rheumatology Group	1,545 | <1%	1,234 | <1%	1,347 | <1%	1,075 | <1%
# Unique Payers	135	133	137	136
# Unique Payer-Plan combinations	6,613	6,629	5,667	6,149
# Records by Payer types	891,421	695,363	735,755	617,544
• Commercial	770,250 | 86%	604,654 | 87%	664,829 | 90%	534,586 | 87%
• Managed Medicaid	31,235 | 4%	23,233 | 3%	16,328 | 2%	19,508 | 3%
• Medicare Advantage	89,936 | 10%	67,476 | 10%	54,598 | 8%	63,450 | 10%

Figure 13