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The Patient Prescription Pipeline: Enhancing Health Equity With Medically Integrated Pharmacies

Alexandra Gerlach, Associate Editor

Health equity remains a persistent challenge in health care, affecting access to timely medications and ongoing treatment across disease states, socioeconomic backgrounds, ethnicities, and races. Patients with cancer and their providers often face a complex web of barriers, including prior authorizations, high treatment costs, and fragmented communication between health care providers, all of which undermine both effective care and patient outcomes. These barriers, coupled with the growing influence of PBM-owned specialty pharmacies (SPs), create a challenging landscape for both patients and providers. However, one potential solution gaining attention is the use of medically integrated pharmacies (MIPs), which was discussed by a panel of experts at the sixth annual National Community Oncology Dispensing Association (NCODA) Oncology Institute in Boston.¹ They explored how MIPs and independent pharmacy networks can play a vital role in improving health equity, ensuring that patients with cancer receive the care they need.

Medically integrated care teams, including MIPs, have emerged as a vital solution

for improving care coordination and access to treatment for patients. These teams, consisting of oncologists, pharmacists, advanced practice providers, nurses, and pharmacy technicians, work collaboratively throughout the patient's cancer journey. Within this model, MIPs play a key role by managing the distribution of medications directly within the clinic where patients receive care, ensuring more cohesive treatment, reducing financial toxicity, and promoting better adherence to therapy, ultimately enhancing patient outcomes.

Shifting from a vertical, isolated care model into a collaborative approach can improve the clinician and patient experience, thereby increasing the quality of care and creating opportunities to navigate inefficiencies more effectively. For patients with cancer who require consistent treatment monitoring or experience sudden shifts in disease progression, the integration of an MIP allows clinicians to provide more effective treatment education, dispense medications directly to patients, get ahead of waste during dose adjustments, and help minimize out-of-pocket costs. Additionally, practices can more effectively maintain control over the distribution network to protect patient

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access, quality of care, and financial viability for practices.

The panel moderator Sharita Howe, PharmD, associate director of partner development and strategy at NCODA, emphasized the importance of deconstructing isolated care models and shared what some of the benefits of an MIP may look like.

“If you move away from siloed care into a more collaborative approach, you can increase those patient outcomes,” she said. “You have mitigation of costs, avoidance of [medication] waste and things like that...A lot of the practices have financial counselors and navigators that’ll assist patients with anything that they may need from a financial toxicity perspective, and then a lot of practices now are doing health disparity analyses.”

Limited distribution networks involve manufacturers partnering with a select group of pharmacies to dispense limited distribution drugs, such as zanubrutinib (Brukinsa, Beigene), under specific contractual agreements.² Limited distribution networks can include independent pharmacies and independent SPs such as Onco360 and Biologics, as well as PBM-owned SPs, including CVS Caremark. However, patients receiving treatments through these mediums often run into significant care obstacles. PBM-owned SPs are vertically integrated, allowing PBMs to direct patients toward external pharmacies for specialty prescriptions and forcing them to navigate the drug distribution system without resources that can be provided by MIPs. Additionally, coordination and communication of care between institutions is often fragmented, resulting in incomplete medical records and poorly managed treatment changes.

The process of getting prescriptions to patients involves several stages with multiple opportunities to either minimize or exacerbate barriers to care. After treatments are prescribed by providers, the prescriptions must go through an insurance verification and approval, preparation, education, delivery, and ongoing treatment monitoring. In SP settings, clinical information may be based off pharmacy and insurance records, which can exacerbate socioeconomic and sociocultural barriers, and they may only provide medication counseling upon request, abandoning opportunities to educate patients to ensure optimal treatment outcomes. Further, many SPs do not offer local pickup options, forcing patients to rely on mail order delivery, which may delay delivery of treatments.

“[SPs] may send that prescription out, or they send out a 60- or 90-day supply, and we all hear of these stories,” said Kathy Oubre, MS, chief executive officer of the Pontchartrain Cancer Center in Louisiana. “But then there’s a dose reduction or a progression in the disease, and therapy needs to change. There are out-of-pocket costs associated with these changes. When we talk about equity and financial toxicity, these are not just buzzwords—they are real challenges we face in caring for our patients.”

The presence of PBM-owned SPs significantly impacts a practice’s ability to retain prescriptions. Without PBM involvement, practices can capture 98% of prescriptions across all insurance types, but this rate drops to 79% when PBMs are involved—and plummets to just 15% if three or more PBM-owned SPs participate. This decline jeopardizes the ability of practices to provide consistent, high-quality care.

Despite the many benefits of limited distribution models, there is ongoing tension between payer relationships, PBMs, and pharmaceutical manufacturers, and the evolving role of independent pharmacy networks in oncology care is increasingly critical as practices seek to maintain autonomy. Practices face challenges with PBMs poaching patients by trying to redirect prescriptions, either through refill requests or direct contact with the patient, making it difficult to keep patients within the MIP network. Additionally, pressure from payers threatens limited distribution models, forcing manufacturers and practices to navigate the fine line of maintaining control over drug access meeting the demands of larger payer systems. These dynamics force practices to continuously find new ways to protect revenue streams and ensure patient access to high-quality, integrated care.

Third-party associations are critical resources for practices navigating the complex relationships between payers, PBMs, and pharmaceutical manufacturers. Bill Karnes, national director, physician networks and strategic partners at BeiGene, shared how these organizations and stakeholders can come together to overcome the challenges posed by PBMs.

“Third party associations, whether they be NCODA or COA, both are very important, because it’s where the stakeholders are really coming together and sharing honest information about what they’re thinking,” he said. “So, it helps us form our internal decisions on stakes that we’re taking. [It could be] a payer pressuring you to contract more with them and take the decision away from the practices to give them more authority. But it’s coming to meetings like this and keeping your finger on the pulse of what’s going on from an industry standpoint [that’s important].”

Limited distribution models supporting MIPs offer a pathway for practices to maintain control over their prescriptions to protect patient health outcomes. Through ensuring that more prescriptions are filled within their own networks, practices can avoid the obstacles of PBM interference and enhance the overall care experience for patients. As independent pharmacy networks and MIPs continue to grow in prominence, the future of oncology care depends on collaboration between payers, manufacturers, and providers to maintain equitable, patient-centered care in an evolving health care landscape

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FTC Sues Major Pharmacy Benefit Managers Over Price of Insulin

Luke Halpern, Assistant Editor

The Federal Trade Commission (FTC) today announced that it is officially suing major pharmacy benefit managers (PBMs) Express Scripts, Caremark, Optum, and their affiliated group purchasing organizations (GPOs), alleging that the corporations engaged in unfair rebating practices that have inflated the prices of insulin drugs and hindered the ability of patients to access them.¹

The suit is months in the making; in July, the FTC released an interim report that recognized the outsized impact PBMs have as middlemen in the pharmaceutical industry, significantly affecting patient accessibility and affordability of critical prescription drugs.²

Shortly after the release of that interim report, multiple sources reported that the FTC was preparing to sue the previously mentioned PBMs, which are the 3 largest in the country, for their alleged unfair business practices. Now, the agency is officially bringing legal action against the corporations.³

“Millions of Americans with diabetes need insulin to survive, yet for many of these vulnerable patients, their insulin drug costs have skyrocketed over the past decade thanks in part to powerful PBMs and their greed,” Rahul Rao, deputy director of the FTC’s Bureau of Competition, said in the news release.¹ “The FTC’s administrative action seeks to put an end to the Big Three PBMs’ exploitative conduct and marks an important step in fixing a broken system.”

Specifically, the FTC is alleging that those 3 PBMs “created a perverse drug rebate system” that led to high rebates from drug manufacturers, inflating insulin prices in the process. Even when lower list prices would become available—potentially making the drug even more affordable for vulnerable patients—the PBMs “systematically excluded them in favor of high list price, highly rebated” insulin.¹

In a corresponding statement on behalf of the Bureau of Competition, Rao does not only criticize the major PBMs that are being sued. Rao highlights the actions of other actors that “have contributed to this broken system,” and that although the FTC is not including them in the suit now, insulin manufacturers Eli Lilly, Sanofi, and Novo Nordisk “play in the challenged conduct.”⁴

That statement alleges that those insulin manufacturers have “sharply inflated” the list price of the insulin products they produce, directly in response to the demands of PBMs for higher

rebates. Rao specifically cites the massive increase in price of Eli Lilly’s Humalog, which was \$21 in 1999 and \$274 in 2017.⁴

“The skyrocketing list price of insulin has had devastating consequences for far too many diabetic patients who have struggled to afford their medication and have been forced to ration these life-saving drugs,” Rao said in the statement.⁴

Millions of Americans with diabetes need insulin to survive, yet for many of these vulnerable patients, their insulin drug costs have skyrocketed...thanks in part to powerful PBMs and their greed.

—Rahul Rao, FTC Bureau of Competition

This suit is poised to be challenged. Already, Express Scripts has filed suit against the FTC regarding the publishing of its July interim report, alleging that the claims made in the report are false and demanding a retraction. In the suit, Express Scripts argues that the report disregards crucial evidence and could raise drug prices in the process.⁵

Voting to file an administrative complaint among the FTC board members was 3-0-2, with 2 commissioners, Melissa Holyoak and Andrew N. Ferguson, recusing.¹

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What Went Wrong: How Formularies, Contracts, and Rebates Created a Headwind for Biosimilars

Mark Campbell, PharmD

The promise of biosimilars was supposed to be simple: more competition, lower costs and better access for patients. Yet as the dust settles from the introduction of adalimumab biosimilars following Humira's (AbbVie) patent expiration at long last, it's clear that formularies have become one of the biggest barriers to realizing the cost-saving potential of biosimilars.

When adalimumab-atto (Amjevita; Amgen), the first biosimilar for adalimumab, launched, its adoption was alarmingly low.¹ As other biosimilars entered the market in quick succession, hopes were high that price competition would soon follow. But the market manipulations enabled by formulary management have instead slowed down the entire process by creating significant headwinds.²

The first installment of this series examined why biosimilars have struggled to make an impact on drug prices. This one looks at how formulary design and the behavioral psychology behind it have played a significant role in this story, resulting in prescribers and patients having to navigate a dense jungle of price points, rebates, and confusing tier placements.

THE ROLE OF FORMULARIES IN SLOWING ADOPTION OF BIOSIMILARS

When adalimumab-atto came to market, the manufacturer offered 2 pricing strategies: one with a higher wholesale acquisition cost (WAC) and another with a lower WAC.² Although both pricing options initially appeared lower than adalimumab's list price, the net cost was often higher once factors like adalimumab's manufacturer copay assistance and the rebate structures favoring the brand drug were taken into account. Overall, adalimumab-atto was often still more expensive than the brand drug, contributing to its slow uptake and sowing

confusion among prescribers and patients regarding its true cost advantage.

As more biosimilars entered the market, there were inconsistencies in how they were placed on various formularies, creating additional confusion.³ Lack of parity in placement and clear interchangeability between biosimilars resulted in a fragmented path to adoption.

When new, lower-cost biosimilars like adalimumab-aqvh (Yusimry; Coherus BioSciences) entered the market—offered at \$569.27 plus dispensing cost, more than 90% below adalimumab's WAC—formulary contracts and rebate structures that had already been locked in for years prevented a quick pivot to adoption by further complicating efforts to capitalize on the potential savings biosimilars offered.⁴

A recent analysis estimated that broader access to adalimumab biosimilars could have saved the health care system up to \$6 billion in 1 year. Instead, these potential savings remain out of reach...

FORMULARIES, CONTRACTS, AND BEHAVIORAL PSYCHOLOGY

The behavioral psychology behind formulary decision-making has played a major role in why biosimilars have not gained more traction. Formulary design, coupled with aggressive branded drug marketing, influences—and some would say manipulates—prescriber and patient behaviors. Branded drug makers use rebates and marketing strategies to maintain market share, even when lower cost biosimilars are available. Status quo bias embedded (and deliberately stirred) risk perceptions surrounding newer biosimilars, and financial incentives tied to rebates from established manufacturers have also played significant roles. Formularies are not just lists of approved drugs—they are also closely tied to complex financial agreements. Two contracts dictate how drugs are accessed: the manufacturer-PBM contract and the PBM-plan sponsor contract. These contracts form the foundation for rebate strategies, pricing negotiations, and, ultimately, the

placement of drugs in the formulary's preferential tiers. Plan sponsors are often locked into multiyear agreements, making it difficult to shift quickly—even when biosimilars like adalimumab-aqvh enter the market with a significantly lower WAC.

PBMs often have an inherent conflict when trying to balance the goal of reducing drug costs with the financial incentive to preserve lucrative rebate structures. Excluding a high-rebate drug like adalimumab or making a sweeping shift to biosimilars could lead to a substantial loss in rebate revenues. Additionally, timing is a critical challenge. By the time adalimumab biosimilars entered the market in 2023, most PBMs had already committed to their formulary strategies for 2024 and 2025, leaving little room for sudden changes.

These structural barriers slow biosimilar adoption, preventing stakeholders from fully capitalizing on their potential to lower costs and improve patient access.

A SLOW PATH TO CHANGE: THE CURRENT STATE OF BIOSIMILARS

After years of challenges, there has been a recent—albeit slow—shift towards biosimilar adoption. CVS Health's decision in early 2024 to give adalimumab biosimilars outright formulary preference over adalimumab resulted in a rapid shift in utilization.⁵ In just 1 week, the biosimilar's market share among patients subject to the CVS Caremark formulary jumped from 5% to 36%.⁵ However, this strategy also left open the option for prescribers to use other, more expensive alternatives to adalimumab, resulting in some erosion of biosimilar opportunity.

Other PBMs, like Express Scripts, have opted for formulary parity between biosimilars and adalimumab, allowing prescribers to choose between the 2 without cost consequences.⁶ This strategy, while more flexible, slows down the conversion to biosimilars, leaving the door open for maintaining the status quo with adalimumab, especially when considering factors such as a high volume of direct-to-consumer advertising for the brand drug, and copay assistance coupons from the manufacturers. All that means the playing field is not actually so level.

Optum has elected to exclude adalimumab from its formulary in favor of adalimumab-atto starting in 2025—a hopeful sign that other PBMs may eventually follow suit and embrace more aggressive biosimilar-adoption strategies.⁷ However, these shifts will only truly benefit the health care system if paired with a commitment to making biosimilars the first-line therapy and closing off more expensive brand-name options.

THE CONSEQUENCES OF INACTION

The slow pace of change in formulary strategies and the reluctance to pivot quickly to biosimilars has had real-world consequences. A recent analysis estimated that broader access to adalimumab biosimilars could have saved the health care system up to \$6 billion in 1 year.¹ Instead, these potential savings remain out of reach, highlighting the inefficiencies in the health care system that favor entrenched brand drugs over lower-cost alternatives.

For biosimilars to reach their full potential, formulary strategies must evolve. PBMs, plan sponsors and health care providers need to be more proactive in removing barriers to adoption and facilitating the transition from biologics like adalimumab to biosimilars. It is difficult to imagine this occurring without a fundamental re-ordering of incentives for those who design and manage formularies—rethinking how contracts are structured, rebates are negotiated and educating prescribers and patients about the benefits of biosimilars. Whether the various entities involved embrace these changes as inevitable, or policymakers and litigators are compelled to intercede, remains to be seen.

The third and final part of this series will explore lessons for the future, including the timing of the biosimilar pipeline, predictions for upcoming high-cost brand patent expirations and what could happen if the industry does not make the necessary changes.

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What Drug Rates Are Reported in Price Transparency Data?

Chris O'Dell

Price transparency legislation has taken health care costs from a best guesser's arena to a transparent, free-market economy in 3 short years. If this is news to you, you're not alone. Rolling effective dates have made it so those subject to price transparency mandates (ie, payers, self-funded employers, and hospitals) also happen to be those most in the know regarding this unprecedented price data; however, this is no longer the case. The pharmaceutical industry is beginning to discover what these data could mean for the commercial success of their pre-launch and in-line products by augmenting contracting, reimbursement and coding, value proposition, trade/distribution, and patient support strategies via data-driven approaches. In this article, the following will be outlined:

- Exactly how price transparency data are sourced and what information can be found in it;
- Publishing trends across therapeutic areas, payers, provider types, billing codes, and geographies;
- And commentary on what all this data means for pharmacists.

PRICE TRANSPARENCY DATA ARE PUBLIC DATA

The Centers for Medicare and Medicaid Services have issued 3 final rules mandating price transparency compliance for hospitals and payers. In addition, the Consolidated Appropriations Act established federal requirements designed to protect and inform consumers. As a quick summary:

- **The Hospital Price Transparency Rule:** Effective January 1, 2021, this final rule mandates hospitals publish standard charges via a machine-readable file (MRF) and prices for 300 Shoppable Services within a publicly accessible patient estimate tool.¹
- **Calendar Year 2024 Outpatient Prospective Payment System Final Rule:** Effective July 1, 2024, this final rule mandates hospitals and health systems to publish machine-readable files (MRFs) according to a standard format that includes new, more detailed data elements. The new required MRF format is coupled with additional measures designed to strengthen and automate enforcement efforts.²
- **Transparency in Coverage (TiC):** Effective July 1, 2022, this final rule mandates payers publish standard charges



via 3 separate MRFs and prices for 500 Shoppable Services within a publicly accessible patient estimate tool.³

- **The No Surprises Act (NSA):** The only federal law influencing price transparency. Effective January 1, 2022, NSA prohibits balanced billing and introduces additional transparency requirements to help consumers know what costs to expect before receiving care.⁴

Pharmacy benefit products are included as a required file to be published per TiC, but the specific enforcement date for this file has been delayed.

Medical benefit drugs are included in hospital MRFs because hospital files must be built on all items and services within a hospital's chargemaster.⁵ Additional drug data are gleaned from payer MRFs which include all contracted rates for items and services. Turquoise Health ingests, parses, cleans, and enriches this medical benefit drug's data for public use, surfacing it in a platform for easy search, analysis, and benchmarking.

WHAT THERAPEUTIC AREAS ARE REPORTED IN THE DATA?

Drug reimbursement data is well-represented across many therapeutic areas, including oncology (eg, gene therapy), immunology, multiple sclerosis, ophthalmology, vaccines,



Health care is now definitively moving toward a transparent, free-market economy. We're measuring it like we might any other market—looking at inflation, trends, and growth.

respiratory, hemophilia, dermatology, the associated biosimilars across therapeutic areas, and more. Within those therapeutic areas, there are over 500 distinct Healthcare Common Procedure Coding System billing codes reflective of Status Indicator G (ie, pass-through Drugs and Biologicals) and Status Indicator K (ie, non-pass-through drugs and non-implantable biologicals, including therapeutic radio-pharmaceuticals).

As we look across different provider types, we see coverage span from ambulatory surgery centers to hospitals and infusion centers. We also see broad coverage in the data as we look to physician groups relevant to any given therapeutic area. For example, we see over 500 oncology groups with reported rates for top cancer drugs. Furthermore, this set of codes is represented and available across all 50 states.

Coverage does vary as you review specific payer, provider, and billing code combinations within the data. However, across rates posted by hospitals and payers, an expansive data set emerges to better understand drug reimbursement across a wide array of provider types, geographies, payers, and therapeutic areas.

WHAT DOES THIS MEAN?

Price transparency data allows you to understand reimbursement trends at scale while also offering the granularity of a single billing code for a given payer and provider with NPI-level

specificity. The intention of price transparency regulations as they are outlined in TiC is “to empower consumers by helping them understand how their plan or coverage pays for health care and to shop for health care items and services based on price, which is a fundamental factor in any purchasing decision.”¹ Based on evidence and research conducted by the HHS, the Department of Labor, and the Department of the Treasury (The Departments), price transparency is “likely to improve competition and lower costs to consumers. The Departments also are of the view that the statute and the final rules do not constitute an abrogation of antitrust law... To the contrary, antitrust law enforcement remains an important tool to protect these markets from anti-competitive behavior.”³ Furthermore, Food and Drug Administration Modernization Act 114 supports the use of truthful economic data to enhance discussions with health care stakeholders.

This is a new and novel dataset that is publicly available and may be utilized in ways that do not violate antitrust law, making it uniquely suitable for pharmacy research for insights into trends in the field. Health care is now definitively moving toward a transparent, free-market economy. We're measuring it like we might any other market—looking at inflation, trends, and growth.

THE POTENTIAL FOR PHARMACY BENEFIT MANAGER RATE REPORTING

Prescription drug reporting for pharmacy benefits could come into play if the Lower Costs, More Transparency Act is passed. This would specifically require pharmacy benefit managers (PBM) to semi-annually report on many additional data elements for a claim submitted, including the brand name, dispense channel, total prescription claims, and the total amount received. They'll also need to report rates expected to be received by the plan or issuer, from drug manufacturers in rebates, fees, alternative discounts, or other remuneration to amounts paid directly or indirectly in rebates, fees (ie, payer's net price). The bill passed a House vote in December 2023; however, no Senate vote has been scheduled. If the bill passes with the PBM reporting requirements exactly as they are written in the draft version, its potential effect on pharmacy will be notable.

The health care industry has never had full, easy access to price transparency data before. We are still discovering how these data can be leveraged and their potential impact. It's largely an untapped wealth of knowledge that everyone from the health economics and outcomes research field to market access teams can utilize.

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Congress Requests Corrections to Testimony From Three Largest Pharmacy Benefit Manager Executives Following FTC Report

Luke Halpern, Assistant Editor

In a letter to the chief executives of the 3 largest pharmacy benefit managers (PBMs) in the United States—CVS Caremark, Optum Rx, and Express Scripts—Chairman James Comer (R-KY) of the House Committee on Oversight and Accountability requested corrections to the record for statements the company leaders made in a congressional hearing in July.¹

During the hearing, titled “The Role of Pharmacy Benefit Managers in Prescription Drug Markets Part III: Transparency and Accountability,” the 3 chief executives “claimed that they do not steer patients to PBM-owned pharmacies,” according to a statement released by the committee.¹

Overall, according to the committee, the CEOs contradicted findings from the Federal Trade Commission (FTC) that provided an overview of multiple aspects of PBMs management of pharmacies the commission deemed unfair, including their contract negotiation processes and opt outs and payments they provided to pharmacies.²

The interim report, released in July, strongly scrutinized the top PBMs in the pharmaceutical industry for unfairly wielding their influence over the affordability and availability of drugs. Lina M. Khan, chair of the FTC, said the report “lays out how dominant PBMs can hike the cost of drugs—including overcharging patients for cancer drugs.”²

As a follow-up to the report, the FTC has signaled its intention to sue the same 3 PBMs targeted by the Oversight Committee for their role in driving up the prices of drugs. The suit would specifically focus on the price for insulin, which can be drastically heightened due to the practice of PBMs providing favorable rebates to pharmacies under their umbrellas, squeezing independent pharmacies out of competition.³

In letters to each chief executive—David Joyner, president of CVS Caremark; Adam Kautzner, PharmD, president of Express Scripts; and Patrick Conway, MD, CEO of Optum RX—Chairman Comer highlighted laws that prohibit making false statements or representations to Congress or violating an

oath, with violators being “fined under this title or imprisoned not more than 5 years, or both.”¹

An additional report prepared by the Oversight Committee detailed their own findings regarding the role of PBMs in health care. Noting that there have been some arguments that the vertical integration structure of PBMs would benefit consumers by improving access and decreasing the cost of drugs, the Committee wrote “instead, the opposite has occurred: patients are seeing significantly higher costs with fewer choices and worse care.”⁴

Over 140,000 documents and communications from the companies form the basis of the committee’s report. “Instead of prioritizing the health of Americans across the country, evidence obtained by the House Oversight Committee shows how the three largest pharmacy benefit managers colluded to line their own pockets,” Comer said in a statement following the hearing.⁵

The recent pressure on PBMs regarding their business practices is notable because of the bipartisan, multi-faceted nature of the response. On the political front, both Democrats and Republicans on Capitol Hill have levied criticism toward PBMs, heightening the possibility of future successful legislative initiatives. Now, the PBMs’ chief executives are being threatened with potential fines or jail time due to alleged violations of US law.

Ron Lanton III, Esq, a regulatory attorney and partner at Lanton Law PLLC, spoke to these recent developments. Although noting significant impacts are unlikely to come from the Committee’s letters to the chief executives because they will likely claim they misspoke or utilized their own sources of information when they answered, Lanton believes that pressure will not be subsiding any time soon.⁶

“The lack of transparency in PBM pricing and network policies has been plaguing independent pharmacies for at least 20 years or more,” Lanton said in an interview. “The amount of independent pharmacies shutting down has risen so much that it has left many communities without a pharmacy.”⁶

Highlighting the bipartisan nature of PBM opposition, Lanton highlighted a particular exchange between Representative Ro Khanna (D-CA) and Conway of OptumRx, in which Conway could not commit to privileging a doctor’s recommendation for a drug over its cost after being repeatedly questioned by Khanna.⁶

“The inability to commit to something as simple as regarding a doctor’s recommendation over costs is an issue that neither party is willing to ignore.”⁶

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