Angus Worthing MD 2024 Testimony - Support - Senat

Uploaded by: Angus Worthing MD

Position: FAV

Angus Worthing, M.D.

SUBJECT: Senate Bill 526 - Health Insurance - Pharmacy Benefits Managers - Specialty Drugs Dispensed by a Physician
COMMITTEE: Senate Finance Committee
The Honorable Pam Beidle, Chair
DATE: Wednesday, February 14, 2024
POSITION: FAVORABLE

I'm Dr Angus Worthing, rheumatologist at ARA. My colleagues and I take care of over 30,000 patients a year at 7 locations in Maryland, Washington DC and Virginia.

I strongly support this bill because it will help prevent some of the most heart-breaking experiences my patients report -- barriers to obtaining their medication.

Patients have told me about many deleterious effects of being forced to use specific pharmacies: extensive time talking with pharmacies and "telephone tag", concerns about mail-order packages of expensive, cold-chain syringes being left on insecure doorsteps at inappropriate temperatures. One patient recently told me that the only way she could avoid mail order was to pick up the pen syringes at a specific chain store that had very long wait times after her long day of work, and this inconvenience caused her to miss drug doses, which caused painful disease flares. Patients with rheumatoid arthritis and other autoimmune diseases pay for delays with their own unnecessary pain and disability. They take stop-gap potentially toxic steroids that can provoke diabetes, broken bones, or serious infections which require costly hospitalization. And after finally receiving mail-order medications, for their first doses they wait still longer to schedule in-person injection teaching.

This bill will help us help our patients by streamlining their care – providing medication and education on injection teaching and handling, at a convenient place from a trusted source i.e. their doctor's office. This year, many patients are moving to biosimilar versions of medication, and we can make that a more effective, cost-effective experience by dispensing their new biosimilar at the point of care. And we can authorize and dispense new doses when we identify disease flares at the point of care.

Please imagine my reply to the grievances of my patients – your constituents -- about pharmacy steering: I tell them that their state protects their choice of pharmacy with all other medications -- it's only the life-changing specialty drug that PBMs and insurance companies can force Marylanders to obtain at certain pharmacies.

Please close this loophole and allow Marylanders to use the pharmacy that's best for them.

SB0526_Pharmacy_Benefit_Managers_Specialty_Drugs_M
Uploaded by: Cecilia Plante
Position: FAV

TESTIMONY FOR SB0526
HEALTH INSURANCE – PHARMACY BENEFIT MANAGERS – SPECIALTY DRUGS DISPENSED BY A PHYSICIAN

Bill Sponsor: Senator Lam
Committee: Finance
Organization Submitting: Maryland Legislative Coalition
Person Submitting: Cecilia Plante, co-chair
Position: FAVORABLE

I am submitting this testimony in favor of SB0526 on behalf of the Maryland Legislative Coalition. The Maryland Legislative Coalition is an association of activists - individuals and grassroots groups in every district in the state. We are unpaid citizen lobbyists and our Coalition supports well over 30,000 members.

The purchase of prescription drugs in Maryland is a confusing and expensive process. Some insurance companies require their members to use specific pharmacies to purchase drugs because their Pharmacy Benefit Managers make more money from those pharmacies. The consumer does not have the opportunity to look around for the best price and usually winds up paying more.

This bill, if enacted, prohibits Pharmacy Benefits Managers from requiring a consumer to use a specific pharmacy for a specialty drug if the drug is dispensed by a physician and used in the treatment of chronic, rare, complex or life-threatening conditions. It also prohibits Pharmacy Benefits Managers from reimbursing a pharmacy or pharmacist in an amount less than the amount the Pharmacy Benefits Manager reimburses itself or an affiliate for providing the same product or service.

Our members are grateful for the support of Marylanders with severe health problems and life-threatening conditions.

We support this bill and recommend a **FAVORABLE** report in committee.

ARAPC Testimony 2024 - Support - Senate Bill 526 -
Uploaded by: Daniel Shattuck
Position: FAV

ARTHRITIS AND RHEUMATISM ASSOCIATES, P.C.

SUBJECT: Senate Bill 526 - Health Insurance - Pharmacy Benefits Managers - Specialty Drugs Dispensed by a Physician
COMMITTEE: Senate Finance Committee
The Honorable Pam Beidle, Chair
DATE: Wednesday, February 14, 2024
POSITION: FAVORABLE

Arthritis and Rheumatism Associates, P.C. is dedicated to the diagnosis and treatment of persons with disorders of the joints, muscles, tendons, and other connective tissue. Our practice integrates excellent medical care with comprehensive services. We maintain a full-service laboratory, x-ray facilities, a physical therapy division, seven centers for the diagnosis and treatment of osteoporosis and seven infusion centers.

Senate Bill 526 *"prohibits a pharmacy benefits manager (PBM) that provides pharmacy benefits management services on behalf of a carrier from requiring a beneficiary to use a specific pharmacy or entity for certain specialty drugs. This prohibition applies if the drug is (1) dispensed by a physician; (2) used in the treatment of a chronic, complex, rare, or life-threatening medical condition; and (3) injected or infused (or an oral drug that meets specified conditions). For a specialty drug that fulfills these requirements (including one dispensed by mail order), a PBM that provides pharmacy benefits management services on behalf of a carrier may not reimburse a pharmacy or pharmacist in an amount less than what the PBM reimburses itself or an affiliate for the same specialty drug."*

Specifically, the bill is aimed to ensure patient access to prescription drugs through the physician dispenser or pharmacy of their choice. This is critical to continuity and efficient care and treatment. Maryland licensed physicians are allowed to personally dispense prescription drugs. A physician may dispense Medicare-covered prescription or nonprescription drugs where he or she is authorized by the State to dispense such drugs as part of his or her physician's license.

Commercial payers have implemented policies that prevent and or limit physician dispensing of drugs, and specialty drugs in particular to their patients. These limitations of a physician's ability to dispense prescriptions to their patients, is a detriment to patient care.

Senate Bill 526 will strengthen patient care by adding provisions that emphasize the importance of patient choice. It will enable patients with complex or chronic conditions like cancer, arthritis, lupus, multiple sclerosis, and more to obtain their medication from the pharmacy of their choice in a timely manner. Patients should be able to choose the most convenient location to receive their medication, whether that's a local independent pharmacy near their home or from their physician's office.

Senate Bill 526 will increase treatment plan adherence, reduce potential waste, and minimize delays-improving overall clinical outcomes. For these reasons we ask for a favorable report.

For More Information Contact: Barbara Brocato and Dan Shattuck
At 410-269-1503, barbara@bmbassoc.com

SB0526_FAV_MDCSCO_HI - PBMs - Specialty Drugs Disp

Uploaded by: Danna Kauffman

Position: FAV

February 14, 2024
The Honorable Pamela Beidle
Chair, Senate Finance Committee
Room 3
East Miller Senate Building
Annapolis, Maryland 21401

Dear Chair Beidle and Members of the Senate Finance Committee:

The Maryland/DC Society of Clinical Oncology (MDCSCO) and the Association for Clinical Oncology (ASCO) are pleased to support **SB 526: Health Insurance – Pharmacy Benefits Managers – Specialty Drugs Dispensed by a Physician**, which prohibits a pharmacy benefits manager (PBM) that provides pharmacy benefits management services on behalf of a carrier from requiring a beneficiary to use a specific pharmacy or entity for certain specialty drugs. This prohibition applies if the drug is (1) dispensed by a physician; (2) used in the treatment of a chronic, complex, rare, or life-threatening medical condition; and (3) injected or infused (or an oral drug that meets specified conditions).

MDCSCO is a professional organization whose members are a community of physicians who specialize in cancer care. ASCO is the world's leading professional society representing physicians who care for people with cancer. With nearly 50,000 members, our core mission is to ensure that patients with cancer have meaningful access to high-quality, equitable cancer care.

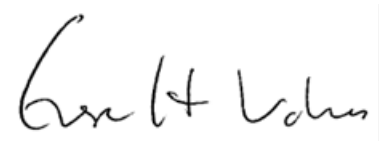
Traditionally, the acquisition of anti-cancer drugs is managed in the independent practice or hospital setting where chemotherapy administration is overseen by the treating physician. The practice or hospital pharmacy purchases, stores, and administers these agents under strict handling and administration standards. Although clinicians prepare detailed treatment plans, drug regimens often change on the day of treatment, due to clinical circumstances. Administration may be adjusted according to criteria, such as patient weight, comorbidities, lab reports, guidelines, and other clinical data. Brown bagging and mandatory white bagging policies remove the physician's ability to control the preparation of drugs. Under a mandatory white bagging policy, insurers require physicians to obtain drugs purchased and handled by payer-owned or affiliated pharmacies, while under a brown bagging policy payers require the drug to be shipped from a pharmacy directly to the patient to bring to the provider's office for administration. Both policies require additional coordination with patients and physicians and could delay or disrupt treatment plans and decisions. Day-of treatment changes can lead to a delay in care if a physician must place a new order, requiring the patient to return on a later date to receive their treatment. This can result in significantly decreased chances of a successful clinical outcome for the patient as well as potential adverse effects on patient health, including toxic reactions.

When treatment plans are modified on the day of treatment, brown bagging and mandatory white bagging policies can also lead to waste if an unused portion of a previously dispensed drug cannot be used for a different patient. Many anti-cancer drugs are highly toxic and require special handling when

discarded. The burden of unnecessary waste related to white bagging and brown bagging falls to practices and hospitals, which must dispose of drugs according to state and federal requirements.

For these reasons, we support Senate Bill 526. For a more detailed understanding of our policy on this issue, we invite you to read the ASCO Position Statement on White Bagging and the ASCO Position Statement on Brown Bagging by our affiliate, the American Society of Clinical Oncology. MDCSCO and ASCO welcome the opportunity to be a resource for you. Please contact Nick Telesco at ASCO at Nicholas.Telesco@asco.org or Danna Kauffman, representing MDCSCO, at dkauffman@smwpa.com if you have any questions or if we can be of assistance.

Sincerely



Dr. Paul Celano, MD, FACEP, FASCO
President
MD/DC Society of Clinical Oncology

Dr. Everett Vokes, MD, FASCO
Chair of the Board
Association for Clinical Oncology

SB0526_FAV_MedChi_HI - PBMs – Specialty Drugs Disp
Uploaded by: Danna Kauffman
Position: FAV

MedChi

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TO: The Honorable Pamela Beidle, Chair
Members, Senate Finance Committee
The Honorable Clarence K. Lam

FROM: Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise
Andrew G. Vetter
Christine K. Krone

DATE: February 14, 2024

RE: **SUPPORT** – Senate Bill 526 – *Health Insurance – Pharmacy Benefits Managers – Specialty Drugs Dispensed by a Physician*

The Maryland State Medical Society (MedChi), the largest physician organization in Maryland, **supports** Senate Bill 526. Senate Bill 526 prohibits a pharmacy benefits manager (PBM) that provides pharmacy benefits management services on behalf of a carrier from requiring a beneficiary to use a specific pharmacy or entity for certain specialty drugs. This prohibition applies if the drug is (1) dispensed by a physician; (2) used in the treatment of a chronic, complex, rare, or life-threatening medical condition; and (3) injected or infused (or an oral drug that meets specified conditions).

For patients with chronic and/or life-threatening conditions, timely access to treatment is critical to avoid medical complications. Patients who are required by a PBM to use a specific pharmacy or other entity often report delays in prescription delivery which, in turn, results in treatment delays. Through years of training and experience in their chosen specialty, physicians are well-informed on the medications that they prescribe to their patients and can advise their patients accordingly. Therefore, MedChi urges a favorable vote on Senate Bill 526 to provide patients with the flexibility to obtain their medications at the venue that they believe will provide them with better care and quality outcomes, which will ultimately benefit the health care system at-large.

For more information call:
Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise
Andrew G. Vetter
Christine K. Krone

410-244-7000

MD SB 526 Support Letter .pdf
Uploaded by: Kelly Memphis
Position: FAV

Healthcare Distribution Alliance
HEALTH DELIVERED

February 14, 2024

Senator Pamela Beidle, Chair
Senator Katherine Klausmeier, Vice Chair
Maryland Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401

Re: Healthcare Distribution Alliance (HDA) Statement of Support for SB 526

Dear Chair Beidle, Vice Chair Klausmeier, and Honorable Members of the Committee:

On behalf of the Healthcare Distribution Alliance (HDA), representing the nation's primary healthcare distributors, I am writing to express our support of SB 2086. If successfully enacted, this legislation would limit the ability of certain entities (Payers/PBMs) to create restrictions on access to physician- administered drugs, a practice known as "white bagging", which has the potential to disrupt patient care.

HDA's distributor members serve as the critical logistics provider within the healthcare supply chain, adding efficiency, security and keeping the healthcare system functioning every day. HDA members work 24 hours a day, 365 days a year to ensure approximately 10 million healthcare products per-day, including specialty drugs, are safely and securely delivered to more than 180,000 providers across the country. In Maryland, our members serve 4,600 points of care.

As referenced above, the practice of "white bagging" is an arrangement between insurance companies and designated specialty pharmacies that they contract with, or own themselves, to ship physician-administered medications directly to sites of care (i.e., hospitals, clinics, doctors' offices) after they have been prescribed by the attending physician. Most U.S. hospitals and physician offices maintain inventories of medications their patients need which can be immediately available when the patient arrives for treatment based on that patient's real-time needs. When a patient's insurance provider interjects and stipulates the drug prescribed by their attending physician, and available at the site of care, must instead be dispensed and shipped from an off-site specialty pharmacy, this practice has the potential to delay access to treatments.

While delaying treatment is burdensome on the patient as well as the physician providing care, white bagging practices introduce additional concerns as well. Such concerns include ensuring the proper storage and handling of these products which in turn may increase provider liability. The creation of increased drug waste due to the product being specified for a specific beneficiary. Most notably for many patients, the process of "white

bagging" may increase costs to the patient as well due to treatment typically being switched from a patient's medical benefit to his/her pharmacy benefit which often includes higher cost-sharing responsibilities.

Complex drug therapies for rare diseases require timely access and enhanced physician oversight of storage, dosing, and administration. Patients trust their doctors to care for them. HDA supports and encourages policies that prevent physicians from delivering timely access and safe administration of medically necessary drugs should be opposed. If you have any questions, please contact me at kmemphis@hda.org

Thank you,

Kelly Memphis
Director, State Government Affairs
Healthcare Distribution Alliance

2024 MCHS SB 526 Senate Side.pdf
Uploaded by: Michael Paddy
Position: FAV

Maryland Community Health System

Committee: **Senate Finance Committee**

Bill Number: **Senate Bill 526 – Health Insurance - Pharmacy Benefits Managers - Specialty Drugs Dispensed by a Physician**

Hearing Date: **February 14, 2024**

Position: **Support**

Maryland Community Health System (MCHS) supports Senate Bill 526 Health Insurance - Pharmacy Benefits Managers - Specialty Drugs Dispensed by a Physician. This bill prohibits a pharmacy benefits manager (PBM) that provides pharmacy benefits management services on behalf of a carrier from requiring a beneficiary to use a specific pharmacy or entity for certain specialty drugs. This prohibition applies if the drug is (1) dispensed by a physician; (2) used in the treatment of a chronic, complex, rare, or life-threatening medical condition; and (3) injected or infused (or an oral drug that meets specified conditions). For a specialty drug that fulfills these requirements (including one dispensed by mail order), a PBM that provides pharmacy benefits management services on behalf of a carrier may not reimburse a pharmacy or pharmacist in an amount less than what the PBM reimburses itself or an affiliate for the same specialty drug.

MCHS is a network of seven federally qualified health centers with 55 care delivery sites across the state of Maryland. Our mission is to ensure underserved communities have access to somatic, behavioral, and oral health care. Community health centers become federally qualified health centers with a special designation by the Health Services and Resources Administration under the Department of Health and Human Services. Access to quality healthcare is essential, and this bill would encourage pharmacy choice which is an important factor in ensuring that patients receive the best possible care. Pharmacy choice allows patients to select the pharmacy that best meets their needs and provides them with the most convenience. This bill removes the artificial barriers established by insurance carriers and PBMs and instead promotes patient choice when choosing a pharmacy which is an important factor in providing quality healthcare.

We ask for a favorable report. If we can provide further information, please contact Michael Paddy mpaddy@policypartners.net.

Maryland SB 526 White Bagging Legislation.pdf
Uploaded by: Camille Fesche
Position: UNF

Maryland SB 526 Will Cost the State Over $1.1 Billion in Increased Drug Costs

A proposed new law in Maryland will bar health insurers from implementing a pharmacy policy known as "white bagging." The proposed legislation will seriously undermine the ability of health plans and PBMs to manage their medical specialty pharmacy expenditures, and as a result, drug spending in Maryland will soar. Restricting white bagging in Maryland could cost the state $99 million in excess drug spending in the first year alone, and $1.1 billion over the next 10 years.

What is "white bagging"?

White bagging allows for a drug to be shipped directly to a patient's health care provider, where it is administered to the patient, from their specialty pharmacy. Claims processing for the drug happens in real time through the drug benefit rather than through the medical benefit, where physician "buy and bill" can lead to payment delays and high costs. The health plan sponsor then reimburses the specialty pharmacy for the ingredient cost of the drug, and sometimes a dispensing fee, and reimburses the provider for the cost of the drug's administration. The cost of these drugs through specialty pharmacies is typically lower than through providers. Use of white bagging has real benefits for patients, providers, and health plan sponsors.

Benefits of White Bagging

For employers, states, federal government, and other health plan sponsors

- **White bagging often is much less costly:** There are meaningful savings for employers, other health plan sponsors, and government health care payers when physician-administered prescription drugs are dispensed through a specialty pharmacy instead of a hospital or provider office that buys the drug and then marks it up, a practice known as "buy and bill."
- **If the current use of white bagging Maryland was eliminated, then costs to the state's health system could reach $1.1 billion over the next 10 years.**

For patients

- **Improved access to care:** "[W]hite bagging can improve access for patients, particularly for patients receiving care with small providers."[1] Patients with physicians who are unable to source, afford to buy, and then store a medication can receive convenient care when a white-bagged medication is delivered to the office just ahead of a visit.
- **Improved affordability and transparency:** Through white bagging, a physician-administered prescription can be covered under the pharmacy benefit, which may have lower patient cost sharing than the medical benefit usually used for physician-administered drugs. In addition, the pharmacy benefit processes the claim in real time, which supports patient awareness of their cost sharing.

For health care providers

- **Real-time claims billing:** Unlike the medical claims process, pharmacy benefit claims processing is handled in real time so that authorization and patient cost sharing are processed upfront. Health care providers know their fees, and claims are typically quickly paid.
- **Temperature Controlled Packaging:** Special white bagged packaging obviates receiving and carefully storing certain drugs prior to administration. White bagging also may support smaller health care providers' treatment of patients without the need to coordinate through a hospital or other outpatient facility.
- **Direct communication with provider:** The specialty pharmacy confirms patient and prescription information for shipping and requires signature upon delivery. Real time changes in dosage amounts are addressed directly with the provider to prevent patient delay in treatment and to mitigate waste. Physician-administered drugs dispensed by a specialty pharmacy usually are for maintenance medications, where dosing is well established and changes in dosing are uncommon.

Projected 10-Year Increases in Drug Spending In Maryland, 2024–2033 (millions)

	Fully Insured Group Market	Individual Direct Purchase	Total
White Bagging Restrictions	$936	$179	**$1,115**

Methodology: The methodology used to create these cost projections is described in "Appendix: White Bagging Dispensing."

[1] Massachusetts Health Policy Commission, "Review of Third-party Specialty Pharmacy Use for Clinician-administered Drugs: Report to the Massachusetts Legislature, Section 130 of Chapter 47 of the Acts of 2017," July 2019, Page 4.

PCMA

AHIP Comments_MD SB 526 Clinician Administered Dru
Uploaded by: Keith Lake
Position: UNF

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February 14, 2024

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East
Miller Senate Office Building
Annapolis, MD 21401

Re: AHIP Opposes SB 526, Clinician-Administered Drugs

Dear Chair Beidle:

On behalf of AHIP and its members, I appreciate the opportunity to share our concerns about SB 526. This legislation would prohibit health insurance providers from structuring benefits and requirements for costly clinician-administered drugs that provide substantial cost savings for Marylanders without sacrificing product safety or the quality of care. Our opposition to SB 526 is based on data and studies included in our comments, which clearly highlights this legislation will undermine affordability and access to care and coverage for the people of Maryland.

Specialty drug prices are high and growing. Everyone should be able to get their prescription drugs at a cost they can afford. Hardworking families should not have to choose between affordable medications and their daily living costs. Health insurance providers are fighting for patients, families, and employers for more affordable medications, and this work is particularly critical when it comes to specialty drugs.

Maryland Insurance Code Section 15-847(a)(5) defines specialty drugs as medications that 1) cost $600 or more for up to a 30-day supply, 2) are prescribed for complex, chronic, or rare medical conditions, 3) are not typically stocked at retail pharmacies, and 4) can have special handling and/or administration requirements. Many of these specialty drugs are administered by a clinician intravenously, intramuscularly, under the skin, or via injection. These specialty drugs are given at a variety of sites of care including hospitals, medical provider offices, infusion centers, and by medical professionals during home visits.

The price of these specialty drugs can range from thousands of dollars per dose to six or seven figures for a full regimen. Both the number and the price of these drugs have rapidly increased in recent years. As a result, specialty drugs are one of the primary drivers of health care spending growth.

- Specialty drug share of net spending across institutional and retail settings has grown from 27% in 2010 to 53% in 2020.[1]
- Nearly one-third of pharmaceutical spending in the U.S. is for clinician-administered drugs.[2]
- Average annual gross spending and average total net retail spending on retail specialty drugs more than doubled from $61.1B in 2010-11 to $157.3B in 2016-17, respectively, and $49.6B in 2010-11 to 112.6 B in 2016-17, respectively.[3]
- Growth in future years will be driven by the number of newly launched drugs, which are expected to continue at record levels, with an average of 50-55 new medications launching per year.[4]

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[1] https://www.iqvia.com/insights/the-iqvia-institute/reports/the-use-of-medicines-in-the-us#:~:text=Specialty%20share%20of%20net%20spending,slowed%20due%20to%20patent%20expiries.
[2] https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2018/02/a-look-at-drug-spending-in-the-us.
[3] https://www.uspharmacist.com/article/net-spending-on-specialty-pharmaceuticals-surging.
[4] https://www.iqvia.com/insights/the-iqvia-institute/reports/the-use-of-medicines-in-the-us#:~:text=Specialty%20share%20of%20net%20spending,slowed%20due%20to%20patent%20expiries.

Markups on specialty/clinician-administered drugs are excessive. Patients, families, and employers are exposed to not only the high price of specialty drugs, but they are also subjected to hospital and physician markups and fees. These markups and fees are well documented and significant:

- JAMA Internal Medicine (2021): The median negotiated prices for the 10 drugs studied ranged from 169% to 344% of the Medicare payment limit.[5]
- Bernstein (2021): Hospitals markup prices on more than two dozen medications by an average of 250%.[6]
- AllianceBernstein (2019): Markups ranged on average 3-7 times more than Medicare's average sale price.[7]
- The Morgan Company (2018). Hospitals charge patients and their health insurance more than double their acquisition costs for medicine. The markup was between 200-400% on average.[8]

AHIP conducted two studies analyzing the cost of 10 drugs that are stored and administered in a health care setting, such as a hospital, but could also be safely delivered through a specialty pharmacy for provider administration. The most recent study[9] examined data from 2019-2021 and found:

- Costs per single treatment for drugs administered in hospitals were an average **of $8,200 more** than those purchased through pharmacies. Drugs administered in physician offices were an average of **$1,500 higher**.
- Hospitals, on average, **charged over double the prices** for the same drugs, compared to specialty pharmacies.
- Prices were **23% higher** in physicians' offices for the same drugs, on average.

These costs were in addition to what hospitals and physicians are paid to administer the drug to the patient.

Using lower-cost specialty pharmacies saves money for patients and helps to make premiums more affordable. Health insurance providers have developed many innovative solutions to make prescription drugs more affordable, including leveraging lower-cost specialty pharmacies to safely distribute certain drugs (sometimes called "white bagging" or "brown bagging").

Specialty pharmacies can deliver drugs directly to a physician's office or to a patient's home right before a patient's appointment. This means that patients can avoid inflated fees and other costs that hospitals and physicians charge to buy and store specialty medications themselves. In addition, specialty pharmacies can improve efficiency in health care delivery, which makes health care more affordable for everyone. Specialty pharmacy staff also help coordinate a patient's care by providing close monitoring, collecting data, and sharing that information between the patient's health care providers. On top of providing these additional, unique services, specialty pharmacies typically provide drugs at a substantial discount as compared to those dispensed by hospitals or physician groups, which leads to cost savings for patients, families, and employers.

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[5] https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2785833.
[6] https://www.statnews.com/pharmalot/2021/01/20/hospitals-biosimilars-drug-prices/.
[7] https://www.axios.com/hospital-charges-outpatient-drug-prices-markups-b0931c02-a254-4876-825f-4b53b38614a3.html.
[8] http://www.themorancompany.com/wp-content/uploads/2018/09/Hospital-Charges-Reimbursement-for-Medicines-August-2018.pdf.
[9] https://www.ahip.org/documents/202304-AHIP_1P_Specialty_Pharmacy_report_update-v02.pdf

It is important to understand that specialty pharmacies offer patients access to the same drugs, from the same sources, using nearly identical shippers who must adhere to the same strict chain of custody and FDA requirements. Here is how both work:

- Hospital/clinicians purchased specialty drugs. Hospitals and clinicians purchase their drugs from a wholesaler or manufacturer or even a specialty pharmacy with whom a manufacturer has a distribution and/or dispending arrangement. The drugs are then shipped to the hospital or clinician who administers the drug to the patient. The patient and employer pay for (1) the drug, (2) the administration of the drug, and (3) hospital/physician markups and fees.
- Specialty pharmacy purchased specialty drugs. Specialty pharmacies purchase their drugs from a wholesaler or manufacturer. Only when safe and appropriate for a particular patient and consistent with strict chain of custody tracking and FDA safety requirements, the drugs are shipped to the hospital or clinician who administers the drug to the patient. The patient and employer pay for (1) the cost of the drug and (2) the administration of the drug.

The proposed provisions of the bill would create an anti-competitive, high-cost clinician-administered drug market in Maryland. If passed, SB 526 would effectively remove any competitive incentive for providers to offer lower prices and higher quality care because health insurance providers would be prohibited from using utilization management tools for these drugs and services. The bill would redirect clinician-administered drugs to hospital-based settings and away from specialty pharmacies, and health insurance providers would not be able to employ benefit design to reward patients for seeking out care at high-quality, lower-cost sites.

In summary, specialty pharmacies improve health care affordability while protecting patient safety. Legislation to limit or eliminate this important cost saving tool will create a statutory monopoly on clinician-administered drugs to hospital-owned pharmacies and leave patients, families, and employers exposed to out-of-control specialty drug prices and excessive physician markups.

Given these concerns, AHIP urges you to not move SB 526 forward. Attached is AHIP's survey for further background information. Thank you for your consideration of our comments.

If you have any questions, please contact me at klake@ahip.org or by phone at 220-212-8008.

Sincerely,

Keith Lake
Regional Director, State Affairs

AHIP is the national association whose members provide insurance coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.