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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.