601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, D.C. 20004
T 202.778.3200
F 202.331.7487
ahip.org

February 27, 2024

Senate Labor & Commerce Committee
House Health & Social Services Committee
Alaska State Legislature
Juneau, Alaska 99801

Re: AHIP Concerns on HB 226 / SB 121 – *Relating to Pharmacies, Pharmacists, Benefit Managers*

Dear Chair Prax, Chair Bjorkman, Vice Chair Ruffridge, Vice Chair Bishop, and Committee Members:

America's Health Insurance Plans (AHIP) appreciates the opportunity to provide comments on HB 226 / SB 121. This proposed legislation attempts to prohibit health insurance providers from structuring benefits and requirements for costly clinician-administered drugs that provide substantial cost savings for Alaskans without sacrificing product safety or the quality of care. This legislation will undermine affordability and access to care and coverage for the people of Alaska and we thus urge you not to move this bill forward.

Clinician-Administered Drugs

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. Specialty and clinician-administered drugs generally are high priced medications that treat complex, chronic, or rare conditions and can have special handling and/or administration requirements. Many 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.

Both the number and the price of these drugs have rapidly increased in recent years and, as a result, specialty drugs are a leading contributor of drug spending growth.

- Specialty drug share of net spending across institutional and retail settings has grown from 27% in 2010 to 53% in 2020.[1]
- 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.[2]

[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.uspharmacist.com/article/net-spending-on-specialty-pharmaceuticals-surging

- Growth in future years will be driven by the number of newly launched drugs, which are expected to occur at higher levels than in past years with an average of 50-55 new medications launching over the next 5 years.[3]

Provider 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 subjected to physician markups and fees. These provider 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.[4]
- Bernstein (2021): Hospitals markup prices on more than 2 dozen medications by an average of 250%.[5]
- AllianceBernstein (2019): Markups ranged on average 3-7 times more than Medicare's average sale price.[6]
- 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.[7]

AHIP released two studies (i.e., 2022 study and 2023 study) where AHIP researchers analyzed 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 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 pharmacies – called specialty pharmacies – to safely distribute certain drugs (sometimes called either "white bagging" or "brown bagging").

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[3] 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.

[4] https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2785833

[5] https://www.statnews.com/pharmalot/2021/01/20/hospitals-biosimilars-drug-prices/

[6] https://www.axios.com/hospital-charges-outpatient-drug-prices-markups-b0931c02-a254-4876-825f-4b53b38614a3.html

[7] http://www.themorancompany.com/wp-content/uploads/2018/09/Hospital-Charges-Reimbursement-for-Medicines-August-2018.pdf

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.

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

- 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 then 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 HB 226 / SB 121 would create an anti-competitive, high-cost clinician-administered drug market in Alaska. If passed, this legislation effectively removes any competitive incentive for providers to offer lower prices and higher quality care because health plans would be prohibited from using utilization management tools for these drugs and services. Health plans would not be able to employ benefit design to reward patients for seeking out care at high-quality, lower-cost sites. Overall, the provisions reveal an attempt to redirect clinician-administered drugs to hospital-based settings and away from specialty pharmacies.

Any willing pharmacy requirements can cause disruption to pharmacy networks, have a significant impact on quality care, and are not effective in reducing drugs costs. HB 226 / SB 121 requires a health plan to pay any pharmacy that dispenses a prescription to a covered individual regardless of whether the pharmacy is in-network or whether the pharmacy meets quality metrics. Also, it prohibits mandatory mail order, resulting in increased access and cost savings for payers and patients.

Health plans contract with PBMs to create a network of pharmacies that compete on cost and quality and provide patients with access to a range of high-quality pharmacies while also providing savings to both payers and patients. These savings are passed on in lower premiums, lower out-of-pocket costs, and better services.

Imposing an any willing pharmacy mandate can also expose patients to pharmacies that lack quality standards, have been sanctioned by the Board of Pharmacy, or banned by Medicare or Medicaid. Additionally, this provision would allow any pharmacy to self-assert they meet the requirements of a "specialty pharmacy." Health insurers have specific standards and criteria that pharmacies must meet to dispense specialty drugs. This includes special equipment, handling, training, storage, and administration, and insurers need to verify that a pharmacy meets the appropriate safety requirements before they allow enrollees to get often incredibly dangerous drugs from a pharmacy.

Mandating that PBMs reimburse in an amount not less than the National Average Drug Acquisition Cost (NADAC) raises patient costs. NADAC is a voluntary database maintained by CMS that pharmacists send their invoice costs to help determine actual acquisition costs (AAC). First, given that NADAC is voluntary, it is in no way reflective of actual costs. Second, there is no data showing the methodology CMS uses to collect such data. For example, we do not know the demographics of the pharmacies that report, or what information is included on the invoice costs, or the geographic variety of the pharmacies reporting. Additionally, not all chain drug stores report their costs to CMS, and the prices do not include off-invoice discount or rebates paid to plans or PBMs from manufacturers. You can see how understanding any and/or all of this data would have a tremendous impact on the output CMS provides.

Further, mandating any reimbursement negates any market competition that would lower costs for patients and cause prescription drug prices to soar. And any attempt to do so based on an incomplete voluntary database would set an extremely dangerous precedent.

Mandating contracting terms between two private parties is anticompetitive and could raise costs. PBMs offer health plan clients a variety of options to pay for PBM services; health plans choose the one that best suits the needs the of the plan. Some health plans choose a pricing arrangement that provides for pre-set pricing on a set of drugs that may have pricing variations; in these arrangements, the PBM is paid for its services by retaining an agreed-upon portion of the rebates that it negotiates with manufacturers. These compensation arrangements are accompanied by reporting and audit provisions in their PBM contracts, to justify the fees and charges made for PBM services. Health plans often choose this compensation arrangement because it provides them with more certainty in their pharmacy costs and allows them to budget in a more predictable manner. Under this arrangement, if a new drug comes to market mid-year that does not offer rebates, the PBM is responsible for managing its entire portfolio of covered drugs to satisfy the pricing guarantee for the health plan. This protects the health plan from rate fluctuations and unanticipated costs that are found in the compensation model that this bill mandates. The predictability incorporated into risk mitigation pricing models is key in maintaining lower premiums as health plans have less risk of volatility for which they need to account. We are opposed to state efforts to interfere with the contracts of two private companies. Reducing options in the marketplace that employer and plan sponsors are currently choosing will ultimately harm them by taking away their flexibility to contract in the best way to suit their needs.

Classifying violations as an unlawful trade practice is unnecessary and will raise costs. Any time you expand violations to include unlawful trade practices, it only invites an extremely litigious system that will undoubtedly disrupt Alaska's insurance market, and lead to higher costs for consumers at a time when they can least afford it. Creating such a system within one that is guided by private market insurance contracts where no misrepresentation to a patient or consumer is involved is inappropriate.

Given these concerns, AHIP urges the Committees not to move forward with this legislation. HB 226 / SB 121 represents a dangerous trend of taking away the few tools that carriers have to hold down prescription drug costs for all consumers. Instead, let us focus on driving down prices at the source, which is the price of the drug set by pharmaceutical manufacturers. By taking this approach, we stand to benefit everyone, including those individuals and small business employers who are struggling enough already.

Thank you very much for your consideration of our comments. AHIP's member plans are eager to continue to work with policymakers and fight for more affordable medications for the residents of Alaska and patients, families, and employers across the country.

Sincerely,

Karlee Tebbutt
Regional Director, State Affairs
AHIP – Guiding Greater Health
ktebbutt@ahip.org / (720) 556-8908