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Representative Tina Liebling, Chairman
House Health Finance and Policy Committee

Dear Representative Liebling,

America's Health Insurance Plans (AHIP)[1] appreciates the opportunity to provide comments to Senate Health and Human Services Committee on House File 544. This proposed legislation would attempt to prohibit health insurance providers from structuring benefits and requirements for costly clinician-administered drugs that provide substantial cost savings for Minnesotans without sacrificing product safety or the quality of care. This will undermine affordability and access to care and coverage for the people of Minnesota.

Specialty drug prices are high and growing. 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. 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.[2]

Physician 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 physician markups and fees are well documented and SIGNIFICANT.

AHIP recently released a new 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 study examined data from 2018-2020 and found:

- Costs per single treatment for drugs administered in hospitals were an average of **$7,000 more** than those purchased through pharmacies. Drugs administered in physician offices were an average of **$1,400 higher.**
- Hospitals, on average, **charged double the prices** for the same drugs, compared to specialty pharmacies, and

[1] America's Health Insurance Plans (AHIP) is the national association whose members provide coverage for health care and related services to hundreds of millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation.

[2] 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.

- Prices were **22% 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").

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. 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.

The proposed provisions of the bill would create an anti-competitive, high-cost clinician-administered drug market in Minnesota. 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. 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. Eliminating this important cost saving tool will create a statutory monopoly on physician-administered drugs to hospital-owned pharmacies and leave patients, families, and employers exposed to out-of-control specialty drug prices and excessive physician markups.

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

Sincerely,

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