



September 26<sup>th</sup>, 2022

Members of the Interim Joint Committee on Health, Welfare, and Family Services:

On behalf of the Pharmaceutical Care Management Association, the national trade association representing America's pharmacy benefit managers, I am writing to restate our concern and opposition to HB 457 and similar policy proposals that would significantly hinder the ability of employers and other plan sponsors to control the soaring cost of prescription drugs. For the purposes of Wednesday's meeting, members should be reminded of the bill's harmful impacts to payors and patients alike. HB 457 contained several rigid and costly mandates which would have removed several cost-saving and quality improving tools used by PBMS, employers and other payors which include:

- Incentivizing the use of more affordable channels, such as mail-order pharmacies or certain preferred pharmacies that result in lower out-of-pocket costs for patients and reduced drug spend for payors.
- Reduced competition through an "any willing pharmacy" mandate that would erode competition and reduce quality by allowing pharmacies with suspect dispensing patterns or past instances of fraud, waste, or abuse into a payor's network.
- Elimination of accreditation standards for specialty pharmacies used to demonstrate that a pharmacy is adequately staffed and equipped to handle complex, expensive specialty drugs. Accreditation standards are a signal to payors that a pharmacy can offer the higher level of service specialty drugs require.
- Granting a monopoly to hospitals and health systems on the sourcing of physician-administered drugs and eliminates the ability of payors to alternatively source these drugs at a more affordable rate from specialty pharmacies equally equipped and accredited to handle and dispense those therapies.

In addition to opposition from PCMA regarding the harmful mandates contained in HB 457, the Kentucky Association of Health Plans, the Kentucky Association of Health Underwriters, and the Kentucky Association of Manufacturers also opposed these measures that would eliminate the flexibility needed to design a prescription drug benefit that maximizes quality and access, while balancing growing costs.

Sincerely,

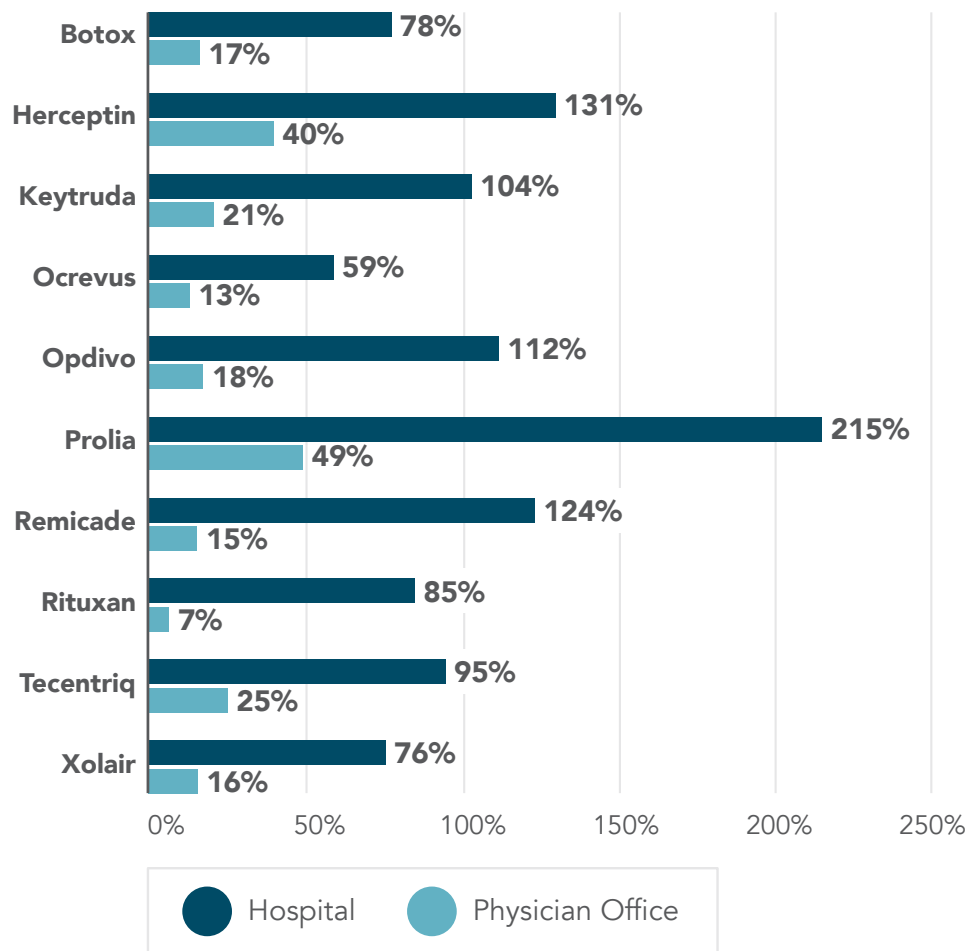
A handwritten signature in blue ink, appearing to read "Connor Rose".

Connor Rose  
Director, State Affairs  
PCMA

# Hospital Price Hikes: Markups for Drugs Cost Patients Thousands of Dollars

**Everyone should be able to get the medications they need at a cost they can afford. But drug prices are out of control, and hardworking families feel the consequences every day.** Health insurance providers have developed innovative solutions to make prescription drugs more affordable, including leveraging lower-cost specialty pharmacies to safely distribute physician-administered drugs (sometimes called “white bagging” or “brown bagging”). These solutions help reduce Americans’ out-of-pocket costs and what they pay in premiums – making health care more affordable and accessible for everyone.

**Figure 1. Average Markups for Drugs in Hospitals and Physician Offices Over Pharmacies (2018-2020)**



Note: Drugs with the highest total spend in 2019, which are also commonly delivered through specialty pharmacies. The drug cost estimate in physician offices and hospitals does not include the cost of administering the drugs

**\$7,000**

**Costs per single treatment for drugs administered in hospitals (2018-2020) were an average of \$7,000 more than those purchased through pharmacies.**

Drugs administered in physician offices were an average of \$1,400 higher.

**108%**

**Hospitals, on average, charged double (108%) the prices for the same drugs, compared to pharmacies.** Physician offices charged 22% higher prices for the same drugs, on average.

Specialty pharmacies lower a patient’s health care costs **by preventing hospitals and physicians from charging exorbitant fees to buy and store specialty medicines themselves.** Secure, direct delivery is more efficient and effective and reduces health care costs.

**Table 1. Average Markup Amounts for a Single Treatment for Drugs Administered in Hospitals and Physician Offices Over Pharmacies (2018-2020)**

Drug	Indication	Physician Office Markup	Hospital Markup
Botox	Chronic Migraine	\$204	\$935
Herceptin	Cancer	\$1,875	\$6,091
Keytruda	Cancer	\$2,031	\$9,956
Ocrevus	Multiple Sclerosis	\$4,433	\$19,803
Opdivo	Cancer	\$1,166	\$7,442
Prolia	Osteoporosis	\$607	\$2,657
Remicade	Crohn's Disease & Psoriasis	\$695	\$5,601
Rituxan	Rheumatoid Arthritis	\$625	\$7,926
Tecentriq	Cancer	\$2,304	\$8,623
Xolair	Asthma	\$349	\$1,654
<b>Average</b>		<b>\$1,429</b>	<b>\$7,069</b>

Note: Markup amounts are estimated for a single treatment. All drugs in the list require multiple treatments.

## Innovative Solutions to Keep Drugs Affordable

Specialty pharmacies improve health care affordability while protecting patient safety. AHIP encourages lawmakers to support the use of specialty pharmacies, and to reject policies that take away lower-cost choices from patients.

## Methodology

The list of drugs included in the study was obtained as follows. From the list of top 25 drugs by spending in Medicare Part B in 2019,<sup>1</sup> we identified, in consultation with our member plans, the drugs that are also commonly delivered through specialty pharmacies. The resulting list included 10 drugs.

For each drug, all medical and pharmacy claims data were extracted from the IBM® MarketScan® Commercial Database for the period January 1, 2018 to December 31, 2020. Using the claims data, we calculated a 3-year average cost for a single treatment for each drug in 3 different settings: (1) specialty pharmacy, (2) physician office, and (3) hospital. All claims were adjusted for inflation to 2020 dollars.

The average cost for a single treatment in specialty pharmacy setting was obtained by dividing the total claim cost of the drug (including both insurance and out-of-pocket costs) by the metric quantity purchased and then multiplying it by the average adult dose per single treatment. The average adult dose per single treatment was estimated based on the dosing information in the FDA approved label.

The average cost for a single treatment in physician office and hospital setting was obtained as the total claim cost for a single day of treatment. When drugs had multiple dosing regimens for different indications, the most common indication was used in calculation. Medical claims were limited to that indication based on the diagnostic codes and dosing frequency.

The physician office and hospital markups were calculated as a ratio of the average cost for a single treatment in physician office or hospital setting to the average cost for a single treatment in pharmacy setting. Similarly, markup amounts were calculated as the difference between the average cost for a single treatment in physician office or hospital setting and the average cost for a single treatment in pharmacy setting.

<sup>1</sup> <https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-medicaid-spending-by-drug/medicare-part-b-spending-by-drug>