TONY KURTZ

STATE REPRESENTATIVE • 50th ASSEMBLY DISTRICT

Senate Bill 753
Thursday, January 20, 2022
Senate Committee on Insurance, Licensing and Forestry

Thank you Chairwoman Felzkowski and committee members for hearing Senate Bill (SB) 753 and allowing me to testify today.

SB 753 prohibits the use of "white bagging" by insurance companies when patients are in network and are prescribed a clinician-administered drug by their provider. White bagging is a practice used by insurance companies that require lifesaving medications to be shipped from a source that they dictate, rather than using the patient's local hospital pharmacy. Patients with conditions like rheumatoid arthritis, cerebral palsy, multiple sclerosis, Crohn's disease, hemophilia or cancer are affected by these policies.

I first learned about white bagging when I visited my one of my rural hospitals in Reedsburg. I met with the hospital staff who told me that they were having issues getting medication for their patients because of this new policy. To hear the patients stories, of having health insurance, paying their premiums every month, and going to a provider that is in their network, and then out of the blue, being told by their insurance company or in some cases informed by their Doctor, that they cannot receive a drug they have been using for their disease, simply because the health insurance provider wants them to go somewhere else so that they may reduce cost. The worst part of this whole situation, is that Hospitals and Insurance companies agree in a contract on the price hospitals will charge insurance companies for every drug. They negotiate and all agree and sign a contract. Yet, insurance companies will change their mind mid-contract, tell the patients they must adhere to their policy changes, or else they will have to foot the bill on their own. This harms one group of people: patients.

I heard from a local patient from Wisconsin Dells about how white bagging affected her. Her name is Christine Schavier, and she has been dealing with severe psoriatic arthritis for the past 17 years. This condition causes severe pain in her joints and affects her ability to walk and perform normal, everyday activities. To help manage her pain, Christine's rheumatologist prescribed an infusion medication that helped with joint swelling and stiffness. She was to receive these infusions in 30-minute appointments at Reedsburg Area Medical Center every six weeks.

She was notified before one of her appointments for an infusion, that her drug had not arrived at the hospital from the specialty pharmacy the insurance company dictated she get her medication from, and therefore she would not be able to receive her infusion the next day if it did not arrive on time. She was told she had to call her insurance company to try and get her drug shipped to the hospital. She couldn't

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believe it, she needed this infusion to be able to be able to move, and now she had to call her insurance company to be able to find out if she would get it on time.

We need to remember people like Christine, who are going through their healthcare journey, and are interrupted from getting the care they need because their insurance company gets in the way. We can't let this become the norm for patients in Wisconsin. We must allow patients and their healthcare team to be in charge of a patient's healthcare journey. We cannot have health insurance companies dictating where a patient gets their clinician-administered drugs. In some cases, this is life or death for patients dealing with cancer or other high risk diseases. They can't wait for the insurance company to figure out their shipping issues. Or in some cases, even if the medication arrives on time, since these medications are mixed several days before a patient's treatment, particularly for cancer patients, the prescribed medications may not be the correct formulation when the patient actually receives the treatment. Patients are being harmed by this practice and that's why we need to make sure it isn't mandated by insurance companies.

Alberta Darling
Wisconsin State Senator · District 8

Testimony before the Senate Committee on Insurance, Licensing, and Forestry

Senate Bill 753

Thursday, January 20, 2022

Thank you Chair Felzkowski and committee members for hearing Senate Bill 753. White bagging is a practice by insurance companies which requires a patient to receive their clinician-administered drugs by a specialty pharmacy selected by their insurance company. The bill before the committee today prohibits certain white bagging practices in order to remove obstacles to patient care.

When an insurance company opts to white bag a drug for patients, the patient's typical medical delivery routine is altered. For some patients, they will need to go to a new location to receive their specialty pharmacy medications, not their usual physician. For many patients, this process causes confusion, difficulties accessing a new care location, and of course anxiety over not being able to use their usual medical team for these medications. In order for patients to keep their providers, they would be required pay the costs associated with receiving out-of-network care.

In other cases, a white bagged drug will be shipped from a specialty pharmacy to the patient's hospital, where the medications will then be administered by the patient's usual care team. This process can cause delays in patient care when medications don't arrive on time or the packaged medicine is not accurate. It can also present a safety concern if the shipped medications are not handled properly. The white bagging process also adds costs to hospitals who are required to receive the shipments, safely store the medication until the patient's appointment, prepare the medicine, and administer it to the patient; but they are only reimbursed for the drug administration benefit.

Senate Bill 753 prohibits insurance companies from mandating white bagging policies. A constituent from my district was negatively impacted by white bagging when a change in his insurance company's policy would have delayed a needed medication, despite the hospital having the same medication available in their pharmacy. After introducing the legislation, I have heard from several additional constituents who have underwent similar experiences. Senate Bill 753 removes obstacles to quality care. Patients shouldn't have to jump through hoops to obtain covered medicine from their in-network provider. White bagging creates patient confusion, disrupts a patient's care routine, and can potentially delay needed care when shipping issues arise for white bagged drugs. This bill ensures that patients have access to the care they need without additional hurdles.

Thank you for taking the time to hear Senate Bill 753. I hope to count on your support for this legislation.

Reedsburg
AREA MEDICAL CENTER

Testimony before the Senate Committee on Insurance, Licensing and Forestry
2021 Senate Bill 753 – "Koreen's Law"
January 20, 2022

TO: Members of the Senate Committee on Insurance, Licensing and Forestry

FROM: Hannet Tibagwa Ambord, Pharm D. MS. MBA,
Director of Pharmacy, Reedsburg Area Medical Center

DATE: January 20, 2022

RE: Support Senate Bill 753 – Protecting Patients from Mandated Insurance Practices

Chairperson Felzkowski, Ranking Member Taylor and members. Thank you for the opportunity to testify today on behalf of Reedsburg Area Medical Center (RAMC). My name is Hannet Ambord. I have been a pharmacist for 25 years, 6 of those years as the Director of Pharmacy at Reedsburg Area Medical Center. As a child, I once needed daily injectable treatment over several days and every time my father and I went to the clinic, we had to wait for several hours because there was no pharmacist, the doctor did it all. It was then that I decided as a 6-year-old child in Uganda, that I wanted to become a pharmacist, so other children like me did not have to wait for hours to receive their medicine. As I fast forward to today, I am here to advocate for my patients that are not waiting for hours as I did, but for days and sometimes weeks, in order to receive life- saving care.

As a pharmacist, I took an oath to always embrace and advocate changes that improve patient care. For the sake of our patients, RAMC embraced and tried white bagging because our patients were not given an option to get their medications from RAMC, or if they did, the medications would not be covered and RAMC would not be compensated for providing pharmacy services.

Many of our patients have been coming to RAMC for years to receive care and their medications have been available to them when their provider and the patient needed them. Unfortunately, this has not been my more recent experience at Reedsburg Area Medical center with the practice of white bagging. The unilateral decisions made by the insurance companies have created an undue burden for our patients, they are increasing our costs and along the way, they are tarnishing the image of our organization.

I have multiple patients that have been impacted. Specifically I am here to advocate for my 78-year-old patient who has been coming to RAMC for years for osteoporosis treatment. Last year she was notified that her medication was to be white bagged and she could no longer receive

her injectable treatment at RAMC. During one of her clinic visits with her doctor in which she would have received her treatment, I stopped by see how she was doing. My patient expressed frustration and a high level of anxiety with the process, she did not appreciate not being able to get her medication during her visit while she was seeing her doctor, in an environment that she was very comfortable with and care from a team that she has known and trusted for years. My patient asked to be switched to another medication that was not on the white bagging list in order to stay at RAMC. She was opting for the next best option, instead of the standard of care.

Just last week, I received a call from a nurse in the clinic, asking me what other treatment options I could offer to a patient who did not want to change treatment but the medication she has been receiving for years is now being white bagged. Patients are opting for the next best option - it's quite disturbing.

Another example is my 53 year old patient with a potentially debilitating inflammatory condition. She has been on medication since 6/4/2020. In working with her Rheumatologist who practices outside of RAMC, the patient chose to receive her treatments, her pharmacy care at RAMC. She received a letter in the middle of her treatment that her medication had to be white bagged. My patient had an appointment scheduled on 10/22/20, but her infusion medication wasn't received until 5 days *after* her appointment on 10/27/20. Her next dose was scheduled for 12/12/20, and the medication was not received until 12/22/20 – 10 days late. Her next appointment was 1/19/21 and medication not received until 02/26/21 – one month and 7 days later. She had an appointment scheduled for 04/13/21 and prior to this appointment we again noticed that no medication was received. Something was not right. I called the patient to check in. My patient shared that "she spent a significant amount of time trying to coordinate her medications and when it would ship out and when to schedule appointments". She said it was quite costly to coordinate everything, taking time off to coordinate her care. In the end, this straw broke the camel's back. Essentially the message we sent to this patient was that, you do not have to take or receive your medications on time as scheduled by your doctor. The back and forth with the specialty pharmacy took a toll, and she decided to stop treatment. The treatment for this patient was interrupted, her quality of life was diminished, and in the end she will have a worse condition. When this happens the overall cost to the health care system is higher, not lower.

Our quality control systems have been disrupted and bypassed with white bagging. We purchase and own our drugs, we monitor dispensing, compounding and dosing, and ensure proper preparation and storage of drugs from purchase to administration. We also complete a full medication review of our patients and adjust dosing in real time based on the patient's condition. With white bagging, we have implied liability and are forced to receive and accept product that is not ours with little to no notice.

Under our normal process, RAMC owns the medications and we can guarantee the point of origin of the drug. We can demonstrate a clear chain of custody to ensure the highest quality product. We follow the Drug Supply Chain Security Act (DSCSA). We cannot just simply hope

and trust that medications were made under safe conditions. The DSCSA standards came about because of concerns resulting from an incident in Massachusetts in 2012. The DSCSA adds a variety of restrictions and regulations especially in regards to labeling, new drug requirements, and track and trace requirements. We saw what happened in Massachusetts in 2012, we must do our due diligence to ensure patient safety.

When drugs are white-bagged, we spend a significant amount of time coordinating medication deliveries instead of focusing on clinical monitoring. We have been put in the "uncomfortable middle man" position between the patient and the specialty pharmacies. Pharmacists are calling patients to apologize even if we have done nothing wrong because the medications did not arrive as expected. They are now coordinating with patients to help them reschedule clinic appointments as needed based on when the medications arrive. There is a lot of re-work and added expense.

At RAMC, like many other hospitals, we have a streamlined automated billing process. After the patient comes to the clinic and receives their medication, the bill is processed using a standard billing system and bill is sent to the payor. With white bagging, the pharmacist must now intervene and manipulate the bill before it goes out to the payor and must work with accounting to document why the bill was changed for audit purposes. This can get complicated especially if patients have more than one medication where some are white bagged and some are not. Now extrapolate this to 10, 30 or 50 patients. As more payors get involved with white bagging we will need to add more staff to manage and over see these dismantled billing systems and processes.

We have other added administrative costs with white bagging as well. For example, we have to segregate and add storage for white bagged medications that have to be held until the patient comes because appointments have been rescheduled. We have tried white bagging and from my own personal experience, it gets messy very quickly. Instead of being lean and efficient, with white bagging our health care delivery systems are being put in "reverse mode." White bagging increases the overall expense to the healthcare system.

I have more similar stories and I have heard many similar stories from my colleagues in Wisconsin. Reedsburg Area Medical center is contracted with these payors to dispense medications to patients. Patient and doctors should have a say and the right to be at the table to decide where to get their medications. As we continue to disrupt patient-provider relationships, our patients suffer. We need to go back to team based care, with the healthcare care providers, payors and patients at the table. Together, we need to answer the question – what is the best for my patient, our patients. With the patient at the center, I believe we can get this right.

Once again, I am here because I took an oath to embrace and advocate for changes that improve patient care. I have never testified before any committee, but I see the disruption to my patients and know that this is preventable. I see quality gaps are being introduced in the

procurement and preparation of these medications, fragmented patient medical records, the implied liability, and the increased cost to the overall health system. If this is allowed to continue, we will need to add staff just to manage this process. Reedsburg Area Medical center asks for your support of Senate Bill 753. Your vote can ensure that this does not happen any longer.

Children's Wisconsin

TO: **Senate Committee on Insurance, Licensing & Forestry**
FROM: **Chris Spahr, MD, Chief Quality Safety Officer, Children's Wisconsin**
DATE: **Thursday, January 20, 2022**
RE: **Support for SB 753, prohibiting mandatory insurance "white bagging" for clinician administered drugs**

I want to thank Chairwoman Felzkowski and members of the committee for the opportunity to share Children's Wisconsin's (Children's) perspectives on SB 753. My name is Dr. Chris Spahr and in my role as a physician and as Children's Chief Quality Safety Officer, I take our commitment to high quality patient care to heart each day and it's what brings me here to express Children's support for SB 753.

Many of you are familiar with Children's Wisconsin. With our top pediatric hospital care, primary care offices, Children's Community Health Plan, various community health programs, child welfare services and more, families across Wisconsin and the country have come to expect the best and safest care for their children when they think of us and we're proud of that. From well-child visits, to broken bones to complex medical issues cared for by the more than 70 specialty areas at Children's, we know that kids aren't just little adults and they require unique and special care, including experts in patient safety and quality.

Over the last few years, health insurance companies have begun implementing a practice, known as "white bagging" which requires that certain medications that need to be administered by a clinician in a health care setting have to be obtained from a specialty pharmacy, often owned by the insurer. In theory, medications are ordered from the specialty pharmacy, which dispenses to the health care provider, who then administers the medication to the patient. In practice though, white bagging has caused a multitude of issues for patient families and the providers who care for them – from medication procurement to drug delivery to patient safety and care. In my role, I focus on reducing risk, promoting safety and working to ensure the best health outcomes for kids.

Medication errors are one of the most common incidences of medical error. The health care system takes these errors seriously and has implemented quality improvement initiatives and safety checks to reduce these types of errors in order to reduce patient harms and improve care delivery. Examples include designing ordering systems to check that the dose is appropriate for a patient's weight, scanning a patient's wristband and the medication to ensure its being delivered to the right patient, and programming pumps that administer intravenous (IV) medications to deliver the right dose at the right rate. These and many other improvements ultimately produce the highest levels of safety when they are linked through one continuous process in our system – from ordering of the medication through delivery and monitoring the patient. White bagging bypasses many of these safeguards and processes that health care institutions set up to protect patients, reduce waste and inefficiency, and allow for the safe provision of health care. I'd like to outline a few examples of these challenges to help demonstrate why passage of SB 753 would help reduce safety risks and disruptions to care for Wisconsin patients.

Currently, the patients most impacted by insurer mandated white bagging at Children's are patients in our specialty care clinics diagnosed with cerebral palsy who are being administered botulinum toxin, most commonly referred to by the brand name Botox. Botox is beneficial for patients with cerebral palsy who experience tight muscles that affect their range of motion, functionality and daily living. Botox helps loosen their muscles so that daily tasks like dressing, diaper changing and placing in car seats are more comfortable for the child and more manageable for the caregiver. These patients receive their medications from a clinician as often as 90 days between injections with some kids being able to go longer in between injections based on their individual needs.

When an insurer mandates white bagging, obtaining the appropriate authorizations for the medications becomes a time-consuming and complicated endeavor. Mandatory white bagging requires increased provider time and patient family engagement even before the drug is able to be shipped. Our clinicians spend hours of time per patient sharing information with the specialty pharmacy who often have inconsistent ordering processes and occasionally have stringent restrictions on discussing patient details which makes it challenging to confirm the correct patient.

Currently, Children's staff have to call the insurer each time (typically every 90 days) prior to the new shipment for the specialty pharmacy to re-verify benefits which takes about three days. Once benefits verification happens and the family gives verbal consent, the drug can be shipped, but not until any balances owed by the patient family to the specialty pharmacy are paid. The drug will not ship until all of these issues are resolved, these steps are complete and any co-pays are collected. Each step often requires direct outreach by Children's staff to the specialty pharmacy or insurer and the patient family. On average this takes 2-3 hours of staff time per patient per shipment to complete this process and resolve any issues even before the drug can be shipped to us. White bagging requires a certain lead time to get the order in and the medication delivered in time for the patient's appointment. For those needing medications more urgently, the time required to complete the white bagging process is frustrating and confusing for families – especially when Children's has most of the medications needed in stock in our own pharmacy.

Children's experiences with the delivery of medications through the white bagging process have resulted in disappointing delays in kids' care. White bagged medications are frequently delivered to the wrong location, which raises questions about chain of custody, confidentiality, and appropriate storage of the medications, not to mention safety concerns if someone was to find the medication and use for other unintended purposes. Patients often make appointments weeks to months in advance, preparing by scheduling time away from work and school. If the drugs don't arrive to us in time due to delivery challenges, this results in delaying much-needed therapies for these patients that is simply out of both their and our control. For example, we have encountered situations where the delivery service does not deliver the medication on the appointed day, retains the medication, and subsequently, appropriate storage conditions were not maintained for an extended duration. We need to ensure that the medications are maintained at the right temperature, and under the custody of trained professionals before administering them. This situation is also repeated when medications are delivered to the wrong site, sometimes to the provider's office which may not have adequate storage or meet refrigeration requirements. Additionally, one of the most common specialty pharmacies won't address the medications to our pharmacy which increases the chance of improper delivery. All of these situations have led to further increasing costs of providing care due to therapy delays or additional costs for the insurer to replace and resend medications that we could've used if they were delivered properly. Issues with delivery and the increased need for provider and patient engagement in this process creates an undue hardship on families who already made schedule accommodations; this certainly isn't optimal for families already stressed by complex medical conditions.

We have heard that some insurers indicate that they have an alternative process to white bagging when an issue arises that would result in delayed administration of the medication; this alternative would instead allow the clinician to administer medication that the hospital has on hand without recourse to the patient or provider. We are not aware of any exceptions in our contracts or that have been conveyed to us in another way. Even if alternative processes did exist, these situations would become extremely difficult to manage from a pharmacy operations and safety perspective. The concept of handing off and communicating information from one team to another is a set up for miscommunication and poor outcomes. Handoffs are at the root cause of many safety events in healthcare. Our goal is to minimize the number of handoffs and improve communications when they need to occur. This is extremely difficult to do in the white bagging process due to different information systems, communication mechanisms (or lack thereof), multiple pharmacies and, in some cases, stringent policies on discussing patient information.

When certain white bagged medications arrive to us, they are in a form that requires reconstituting or compounding – essentially making the drug usable for a particular patient. This is an important and costly step in the process that requires specialized facilities and trained staff to ensure the safety of patients. Additionally, white bagged medications come with burdensome storage requirements we must follow which include ensuring that each medication is stored by individual patient and for their use only. This requires additional storage space which is exacerbated when appointments are cancelled or changed or patients are unable to complete their treatment regimens. White bagging also poses challenges to providing high quality care during the patient's appointment. For example, if a patient usually takes a

certain dose of their medication but their condition, via testing and other checks at the time of appointment, requires a different dosage of medication, the insurer pharmacy has only filled their usual dose. When white bagging is mandated, a required dose adjustment like this would often result in a delay in care as we would have to process a new order, await the shipment of the remainder of the dose, and have the patient return for another appointment in order to proceed with therapy. Due to the long lead time for shipment, we could not even consider delivering one dose in two separate administrations as it would result in suboptimal care. If not for white bagging, we could simply adjust the dose at the time of the appointment to have our pharmacy prepare and deliver what is needed, providing better health outcomes for the patient and reducing appointment scheduling burdens.

White bagging policies also state that these medications can't be used for other patients – if the patient doesn't use their dose, cancels their appointment or changes treatment regimen, the drugs we've ordered for them must be destroyed. Additionally, white bagging doesn't allow for many of the clinical, safety and quality checks that are built into health system pharmacy workflows. This is especially important in pediatrics as many drugs are formulated with adults in mind. Our pharmacy staff are specially trained in kids' anatomy, illnesses, metabolisms and how all of these could impact how a medication may interact with a patient. The specialty pharmacies that insurers require we order from do not have this training or access to medical records, which has resulted in medication dosing errors that can be dangerous to the patient and potentially further delay care when they're discovered. Recently, a medication was sent for a patient with the instruction to inject 10 mg weekly for four weeks, but the patient should have been receiving 2.5 mg weekly. This particular medication has the potential for anaphylactic reaction so must be carefully administered to gauge the patient's reaction and maintain their health and safety. Very fortunately, our Children's pharmacist caught the specialty pharmacy's dosing error.

Overall, the white bagging process and its requirements are incompatible with how health system pharmacies order, store and dispense medications for patients, creating a separate and often confusing and frustrating system for staff and patient families alike. Because of the varied shipping and ordering services used, it makes tracking these issues and concerns a real challenge. SB 753 would prohibit this practice which we believe would improve access to these critically needed specialty medications in a more timely, efficient and safe manner. Of course, while white bagging has an impact on Children's Wisconsin's ability to provide safe, high quality care for kids, more important are the voices of the patients and their families who experience these challenges and the impact they have on their children's healthcare.

I'd like to share a brief statement from the family of 8-year-old Landon Claeys from Grafton who could not be with us today. *We are Megan and Mike and we live in Grafton with our sons, Robbie and Landon. We'd like to share more about our 8-year-old son Landon. Landon has cerebral palsy due to brain damage sustained at birth. Landon's cerebral palsy affects his motor control, sensory processing and his reflexes. Landon's doctors at Children's Wisconsin have used Botox injections on a regular basis to help loosen Landon's muscles that get tight which make it harder for him to do daily activities and causes him significant pain. We regularly scheduled his injection appointments for every three months so we could better manage Landon's muscle pain and tightness and allow us to plan for time away from school and work.*

A couple of years ago, our insurance company suddenly started a policy, called white bagging, which would change the process for how Landon would receive his medications. Rather than using the medicine already in stock at the hospital's pharmacy like we were used to, Landon's doctors would have to order the medication from a specialty pharmacy that would then ship the medicine to the clinic for the appointment. Because of insurance company approvals and shipping delays, we had to reschedule an appointment of Landon's – unfortunately, the new appointment would be a month later and a month of Landon experiencing pain and hardship. Also, depending on how Landon's condition is at the time of the appointment, Landon's doctors and nurses may need more doses of Botox injections. With this white bagging process, we'd have to come back for another appointment once the additional doses were ordered and delivered. Before white bagging, the hospital could just use their stock of Botox to meet Landon's needs and made scheduling and the whole process simpler for us. For kids and adults with complex or chronic health conditions, navigating the health care system is already complicated, stressful and sometimes frustrating. Eliminating this policy, and supporting SB 753, would help health care providers to better care for kids like Landon. Thank you.

Hospitals don't usually raise issues with our elected officials that we normally negotiate in the contracting process with insurers. What is different about this issue is that insurers are implementing these mandated policies outside of the

regular contract with sometimes not more than 60 days' notice. While right now mandatory white bagging policies have been limited to select insurers and specialty drugs, our experience indicates this practice will grow and impact more and more patients, as well as negatively impact quality health care delivery. That's why it is important for the Legislature to act swiftly in moving this legislation forward. In short, we have issues with insurers' inflexible, mandated white bagging requirements as they compromise patient safety, timely and adequate care, and disrupt the day-to-day lives of kids and families. Thank you for the opportunity to share Children's Wisconsin's perspectives on this legislation which will have a significant impact for the children and families across our state who depend on specialty medications. I'm happy to answer any questions you may have.

Chris Spahr, MD
Chief Quality Safety Officer, Children's Wisconsin
spahr@chw.org

Children's Wisconsin (Children's) serves children and families in every county across the state. We have inpatient hospitals in Milwaukee and the Fox Valley. We care for every part of a child's health, from critical care at one of our hospitals, to routine checkups in our primary care clinics. Children's also provides specialty care, urgent care, emergency care, dental care, school health nurses, foster care and adoption services, family resource centers, child health advocacy, health education, family preservation and support, mental health services, pediatric medical research and the statewide poison hotline.

Coalition of Wisconsin Employer Groups Concerned About Health Care Costs

TESTIMONY IN OPPOSITION TO SB 753

WILLARD T. WALKER, CEO OF WALKER FORGE, INC.

SENATE COMMITTEE ON INSURANCE, LICENSING AND FORESTRY

JANUARY 20, 2022

1. I am Willard Walker, CEO of Walker Forge, a 350 employee company with locations in Milwaukee and Clintonville, Wisconsin. I am testifying on behalf of our company and the Coalition of Wisconsin Employer Groups Concerned about Health Care Costs. The coalition is made up of a growing number of Wisconsin businesses who are learning about this legislation and are opposed to it.
2. Wisconsin's health care prices are already higher than almost every other state in the country. Wisconsin employers and their employees are already struggling to pay for health care, and passage of this legislation would drive up costs even more, making the situation even worse. This legislation is inherently anticompetitive because it would force health plans to purchase certain high-cost medications through hospital-controlled pharmacies instead of sourcing the medications from other reputable specialty pharmacies at much lower cost.
3. Let's be clear -- Wisconsin employers and their employees have the biggest stake in this fight -- it is employers and employees who foot the bill for most of the health care delivered in Wisconsin. Health care costs are the second or third biggest expense for

employers, right behind payroll and, at some companies, raw material. Employers bear the initial cost of health care premiums, but it is employees who ultimately bear most of the costs of employer-sponsored health benefits, through a combination of: 1) employee premium contributions, 2) employee out-of-pocket costs, and 3) employer contributions for health care that take the place of other forms of compensation, such as wages and retirement benefits. Health care costs are, in essence, a tax on employees.

4. Wisconsin already ranks near the top nationally in terms of health care prices. Indeed, a 49-state national study[1] published by the Rand Corporation (a nonprofit research organization) in September, 2020 showed that Wisconsin has the:
    a) 3rd highest prices for physician and other professional services,
    b) 7th highest prices for outpatient services,
    c) 10th highest hospital prices, and
    d) 12th highest prices for inpatient services.
5. The price of health care has reached these heights because Wisconsin hospital systems have: 1) acquired tremendous market power through anti-competitive mergers and acquisitions of competing hospital systems, clinics and physician groups, and 2) made it very difficult (if not impossible) to shop for health care by keeping prices hidden from the public. The hospitals keep their prices secret by inserting gag clauses in their contracts with health insurance companies. The resulting lack of price transparency prevents both employers and consumers from being able to shop for health care in a free

[1] "Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative." Brian Briscombe, Rose Kerber, Brenna O'Neill and Aaron Kofner, September 2020.

market, and results in widely varying prices for the same procedure from one hospital to the next, and even within the same hospital system.[2]

6. The hospital systems, having stifled competition through anti-competitive mergers and acquisitions and by keeping prices secret, now seek to fatten their profits and enhance their market power by seeking a legislative ban on employers' ability to control costs through alternative sourcing of specialty drugs. I call it "alternative sourcing" instead of the pejorative "white bagging".

7. Hospitals are keenly focused on these specialty medications because they are very lucrative for hospitals. Studies show hospital mark ups on the acquisition cost of these medications average between 200% - 400%.[3] These markups are in addition to the amounts hospitals separately bill insurers and employers for the professional services required to administer the medications. Furthermore, hospitals often earn "extraordinary profits" by acquiring these specialty medications at a discount under the federal 340B Drug Pricing Program.[4] If this legislation passes, those mark ups will almost certainly increase as free market principles are thrown out the window—patients and purchasers will be forced to pay whatever the hospital charges for drugs. What do you think will happen to the markups on these medications once that happens? Higher prices resulting from passage of this bill would impact everybody--all employer sponsored health plans (both fully-insured and self-funded) and all consumers of health care.

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[2] Boulton, G."Study for the first time sheds light on prices for specific Wisconsin Hospitals." Milwaukee Journal Sentinel, September 29, 2020. https://www.jsonline.com/story/money/business/health-care/2020/09/29/wisconsin-hospital-price-comparisons-revealed-first-time-study/3513647001/

[3] The Moran Company, Hospital Charges and Reimbursement for Drugs: 2019 Update Analysis of Markups Relative to Acquisition Cost, July 2019

[4] https://www.marwoodgroup.com/wp-content/uploads/2021/11/White-Bagging-Whitepaper-11_24_2021.pdf p.3

8. Walker Forge is a perfect example of why the legislature should not pass this legislation, and should instead encourage Wisconsin employers to use free market principles to control health care costs. In fact, the state should start buying health care for its own employees using the same principles we do. For most of the last 20 years Walker Forge, like most other employers, struggled to provide affordable health care coverage to our 350 employees. Our health care costs increased every year and limited our ability to increase wages. Dollars we spent to cover higher health care costs could not be spent on wage increases. In addition, we shifted costs to our employees by raising employee health care contributions, deductibles and out of pocket limits. Walker Forge finally reached its breaking point several years ago. We decided to change our whole approach to health care and re-designed our self-funded plan to use the free market to control health care costs, and incentivize our employees to be smart consumers.
9. Walker Forge now makes health care available to our employees for free. By free, my reference is to the care, not employees' contributions to the effort. Employees still pay a premium contribution to participate. But after that, we make primary care and specialty care (including mental health care) available for free to employees who seek care from high value providers. Walker Forge self-funds its health plan, and self-funding gives us the flexibility to design our plan the way we want and in compliance with ERISA.
10. Walker Forge uses the free market to take so much waste and unnecessary cost out of health care that we can offer free health care to our employees and still achieve lower overall cost. Walker Forge has collaborated with three other employers to establish a free clinic so our employees and dependents can get the primary care they need without having to pay the exorbitant prices charged by the area hospital system. When specialty

care is required, we make it available for free through high value specialty care providers with whom Walker Forge has negotiated direct contracts.

11. With its free market approach to health care, Walker Forge has been able to offset annual health care inflation completely for several years running, thus premium contributions paid by our employees have remained flat for 3 consecutive years, saving each Walker Forge family more than $1,000 in premium increases. On top of that, Walker Forge's all-in health care spending per employee is 28% below the national average.[5]

12. It is very concerning that the legislature, at the urging of the Wisconsin Hospital Association, is considering taking away one of the important tools Walker Forge and other employers use to control health care costs for the benefit of our employees. Walker Forge has employed alternative sourcing very successfully and without objection or disruption. And we have done it safely. Our company policy is quite simple: if the prescribed medication cannot be alternatively sourced and delivered on time, then allow the hospital to source the medication. But Walker Forge has not had any occasion to act on that policy because alternative sourcing has not resulted in any delays or disruption, not even once. We care about our employees and their dependents, and we want to make sure they receive medication when they need it. But we also care about protecting our employees from unnecessary health care costs. Alternative sourcing saved our company and employees more than $170,000 in 2021, which works out to about $500 per employee.

13. Walker Forge is an example of what can be achieved when employers choose to apply free market principles to health care--and the biggest beneficiaries are the working men

[5] See Mercer 2021 National Survey of Employer Sponsored Plans

and women of Wisconsin. The state legislature should be doing everything it can to support, encourage and emulate Wisconsin employers' use of free market principles to control health care costs.

14. Hospital opposition to alternative sourcing is grounded in lost revenue and reduced profit from the traditional "buy and bill" method of medication purchasing.[6] Many of these medications are extraordinarily expensive, and hospitals mark them up so substantially that costs can run as high as $30,000 to $50,000 per injection or infusion, or even more.
15. Buy and bill is extremely profitable for hospital systems, and this explains the growing trend of hospital provider-integrated pharmacies. Specialty pharmacies owned by hospitals, health systems, physician practices, and provider group purchasing organizations have more than doubled as a share of accredited specialty pharmacy locations over the past several years.[7]
16. This legislation should not be passed because new legislation is not necessary to protect patient safety or protect patients from delays and disruption. Employers and their insurance companies all have a strong incentive to have in place policies and practices to avoid delays and disruption. There is no basis for asserting that alternative sourcing cannot work well and provide patients the drugs they need in a safe and timely manner. Another example of successful alternative sourcing is Purdue University. Under the leadership of former Indiana Governor Mitch Daniels, Purdue has embraced alternative sourcing, building in a process to ensure patients receive their medications in a safe and timely manner, and saving approximately $2.5 million on specialty medications in the

[6] https://www.marwoodgroup.com/wp-content/uploads/2021/11/White-Bagging-Whitepaper-11_24_2021.pdf p.4
[7] Ibid., p.3

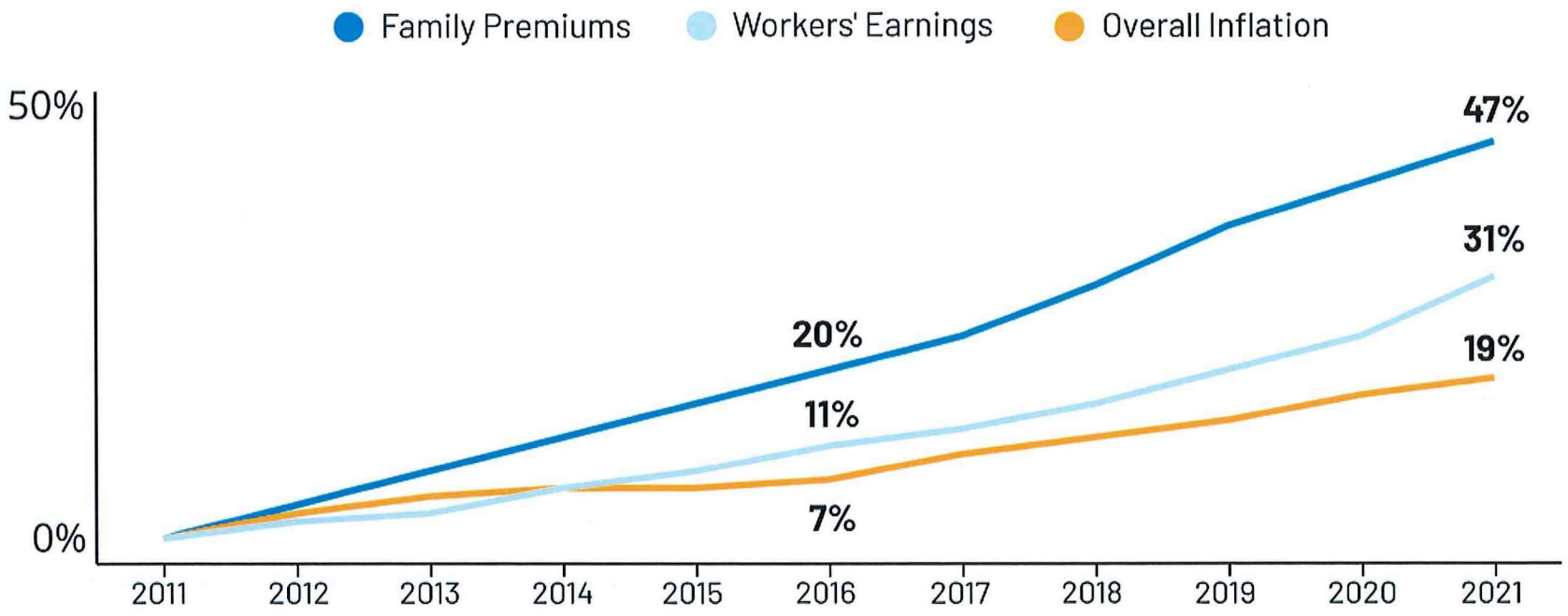
first quarter of 2021.[8] Walker Forge and Purdue University are examples of employers successfully using alternative sourcing to meet the needs of patients while controlling health care costs.

17. Legislators need to be aware need that if this legislation does become law, self-funded employers may be left with no other choice but to exclude certain high cost medications from coverage. Most of Wisconsin's largest employers, more than 600 in all, have chosen to self-fund their health plans, and each of these employers is legally entitled to exclude specific drugs from coverage. Employers care about their employees, and no employer wants to be put in the position of having to make that kind of decision, but passage of this legislation may lead to this unfortunate result.
18. In conclusion, this legislation would cause health care costs to increase, and harm the people who ultimately foot the bill – the working men and women of Wisconsin. The free market is the solution to Wisconsin's unsustainably high health care prices. Legislators should stand with employers and employees who want and deserve high quality health care at an affordable price, and resist this brazen attempt by hospitals to choke off the free market.

If you have any question, please do not hesitate to reach out to me at willard.walker@walkerforge.com

[8] https://www.indianaruralhealth.org/clientuploads/Advocacy/HEA_1405_Specialty_Drug_Report_July_2021.pdf

Over Time, Family Premiums Have Risen Faster than Wages and Inflation



SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 2011-2021; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2011-2021.

KFF

milwaukee journal sentinel

HEALTH CARE

Study for the first time sheds light on prices for specific Wisconsin hospitals

Guy Boulton Milwaukee Journal Sentinel

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The prices that employers and employees pay overall for health care are 38% higher at Aurora St. Luke's Medical Center and 23% higher at Froedtert Hospital than at Ascension Columbia St. Mary's Hospital Milwaukee.

Those are just a few examples from a study that for the first time provides information on what specific hospitals charge private health plans in the Milwaukee area and throughout the state.

It is information that has been largely kept confidential by health systems and health insurers.

"That's the problem — the lack of transparency in health care around price," said Cheryl DeMars, the CEO of the Alliance, an employer coalition based in Madison. "And by that I mean the money that is coming out of the pockets of employers and their employees — the people who are actually paying the bills."

The study is a step toward changing that.

Compare Wisconsin hospital costs: Search our price comparison database

It was done by Rand Corp., a nonprofit research organization, as part of a national study and was based on insurance claims paid by employers who offer health benefits.

Companies that belong to two employer groups — the Business Health Care Group based in Milwaukee and the Alliance — as well as other employees in Wisconsin provided their insurance claims to the researchers at Rand for the study.

The study shows the wide variation in hospital prices, even among hospitals within the same metro area and the same health system.

For example, prices at Aurora Health Care's hospitals in Milwaukee and Cudahy are 32% higher than those at Aurora West Allis Medical Center, and prices at Ascension Columbia St. Mary's Hospital Ozaukee are 25% higher than those at its sister hospital in Milwaukee.

The study also raises the question why the prices paid by health plans are 32% higher at Aspirus Wausau Hospital than at ThedaCare Regional Medical Center in Neenah or why they are 46% higher at Froedtert West Bend Hospital than at Gundersen Lutheran Medical Center in La Crosse.

"There's a dramatic difference in what they are getting paid," said Dave Osterndorf, an actuary and a consultant to the Business Health Care Group. "So, this whole idea that nobody is able to do OK at lower price levels is pretty strongly belied by the facts."

The Rand study used the set rates that Medicare pays for hospital inpatient, outpatient and physician services as a benchmark to show what employer health plans pay for the same care.

Compared to the rates that Medicare pays, the prices paid by health plans are:

3.46 times higher at Aurora St. Luke's Medical Center, Aurora Sinai Medical Center and Aurora St. Luke's South Shore.
3.08 times higher at Froedtert Hospital.
2.89 times higher at Waukesha Memorial Hospital.
2.77 times higher at Aurora Medical Center Grafton.
2.51 time higher at Ascension Columbia St. Mary's Hospital Milwaukee.
2.1 times higher at the Orthopaedic Hospital of Wisconsin.

"Having the benchmark to Medicare allows us to ask the question, 'What is the fair price?'" DeMars said. "We are dealing with the increasing unaffordability of health care for people."

The benchmark also shows that some hospitals and health systems have much lower prices.

"It demonstrates that things don't have to be the way they are," DeMars said.

Nationally, the Rand study found that private health plans offered by employers pay on average 247% of what Medicare pays for the same care. In Wisconsin, prices on average are an estimated 2.9 times — or 290.5% — higher than what Medicare pays.

It works out to 17.6% more than the national average — and 53% more than employers and employees pay in Michigan and 41% more than they pay in Pennsylvania, two of the states with the lowest costs.

Wisconsin had the 10th highest hospital costs overall in the national study. By specific services, the state had the:

2nd highest prices for physician and other professional services
7th highest prices for outpatient services
12th highest prices for inpatient services

Studies have shown that hospital prices and physician fees are higher in Wisconsin, particularly eastern Wisconsin, for years. But the Rand study allows employers and others to compare costs at specific hospitals.

The study also found that prices continue to increase: They rose an estimated 10% on average nationally from 2016 to 2018.

"The trend is going very much in the wrong direction," Osterndorf said. "A lot of this conversation that we somehow have costs under better control really isn't true."

Hospital services account for 40% to 60% of private health plans' medical costs, which exclude prescription drugs and administrative costs, he said.

Increasing burden of health care

About 153 million people nationally get health insurance through an employer. And with deductibles that can total $10,000 a year for a family, the cost of health care has become a burden even for people with insurance.

"Health care is unaffordable," said Jeff Kluever, executive director of the Business Health Care Group. "It's just that simple."

The Wisconsin Hospital Association said it still was reviewing the study.

"We caution against drawing sweeping conclusions until a more robust review and analysis can be completed," Eric Borgerding, the CEO of the hospital association, said in a statement.

The Wisconsin Hospital Association released its own study days before the national Rand

study was released.

That study — done by HC Trends, a research affiliate of BSG Analytics in Pewaukee — found that Wisconsin has high value health care when taking into account quality and efficiency.

But Osterndorf said that implies that the lower-prices hospitals and health systems in Wisconsin are not efficient.

"And there is no indication that Froedtert is more efficient than ThedaCare," he said.

The Rand study instead shows that Froedtert Hospital's prices are 23% higher than ThedaCare Regional Medical Center — and that Froedtert West Bend Hospital's prices are 49% higher.

Studies also have shown that prices are the main reason health care costs continue to increase for employers and employees.

"It's not surprising that the trade association would criticize the study," DeMars said. "But I think it is difficult to find anyone who is defending the status quo or believes that health care doesn't cost too much."

Affordability a goal for some systems

There are physicians and health systems, she said, that want to make health care more affordable.

Tim Bartholow, a physician and chief medical officer of NeuGen, which manages health plans for WEA Trust and Health Traditions, also said there are examples throughout the state of health system that are working to provide quality care a lower price.

A new employee who makes $30,000 a year now can have a deductible of $2,500 or more, he said. And many if not most physicians are becoming more aware of costs, but they need more information on prices.

"There is a dramatic absence of information on the cost of care that doctors have available to them," Bartholow said.

Economists contend that the cost of health benefits — which are part of total compensation — comes from workers by limiting what employers can pay them.

"If you are a worker, those rising health care costs are coming directly out of your paycheck," said Christopher Whaley, a policy researcher at Rand and the study's lead author.

Study reviewed $33.8 billion in claims

The national study was based on approximately 750,000 claims for inpatient hospital stays and 40.2 million claims for outpatient services, including physician and other professional fees, from 2016 to 2018. The Wisconsin claims data is just for 2018.

The claims totaled $33.8 billion and were primarily from employers who self-insure, or pay most of the health care costs of their employees and families, in 49 states and the District of Columbia.

Six states also contributed data from what are known as all-claims databases. And a few regional insurers contributed claims.

The study was paid for by the Robert Wood Johnson Foundation, which funds research and programs on health care, and the employers who contributed their claims data.

The study builds on two previous studies by Rand — the first done in collaboration with the Employers' Forum of Indiana, the Indiana counterpart to the Business Health Care Group and the Alliance.

Wisconsin employers, including many of the largest employers in the Milwaukee area, contributed one of the largest data sets of the states, said Kluever of the Business Health Care Group.

"We are going to keep our foot on the pedal as it pertains to data and utilization of that data for measurement," he said. "This is not a one and done study."

Rand has begun work on a fourth study, Kluever said, and he expects even more state employers to contribute data for that study.

Getting the claims data for the most recent study, though, took some work.

"The employer community has really pushed hard to get data passed along to Rand," Osterndorf said.

Insurers often are reluctant to give claims data to employers. And many contracts between

health systems and insurers prohibit sharing detailed information on prices with employers and patients.

As a result, researchers often are barred from identifying specific hospitals in studies on costs.

(The Trump administration last year issued a rule that will require health systems to disclose the prices that they negotiate with insurance companies. The American Hospital Association sued to stop the rule from going into effect. A federal judge sided with the administration this summer, but the hospital association has said it will appeal the decision.)

The researchers at Rand were able to sidestep the contracts between health systems and insurers by not disclosing the prices negotiated for specific services, such as a knee replacement, or for specific health plans.

They instead compared the overall prices to Medicare rates, which are set prices with some variation for the cost of living and other variables.

The Wisconsin Hospital Association noted that the study was based on just 3% of the payments from commercial health plans to Wisconsin hospitals.

But Whaley was confident that the sample size for the state — more than $300 million in medical claims for 2018 — was adequate.

The study required a minimum number of claims for each hospital, though the results for Mayo Clinic Health System's hospitals in La Crosse and Eau Claire, which had the highest prices in the study, may not reflect the actual costs. This is because of the small sample size and because the hospitals are not in some health plans' networks.

But Osterndorf said that the study is transparent on the number of claims for each hospital and includes supplemental material on the data.

"There is nothing hidden here, and I give Rand a huge credit for that," he said. "You do not usually see this amount of backup information in a study such as this."

The study's goal was to provide employers with information about the prices they and their employees are paying for hospital services.

That, though, is just the first step.

"A big part of this," Osterndorf said. "is employers simply have to do something with it now."

Correspondence Memorandum

Date: Wednesday, January 19, 2022

To: Senate Insurance, Licensing and Forestry Committee

From: Coalition of Wisconsin Employer Groups Concerned about Health Care Costs

Re: Assembly Bill 718/Senate Bill 753 Concerns

Wisconsin businesses of all shapes and sizes are regularly facing a multitude of barriers. The past two years have been extremely difficult to navigate. Yet with all the pandemic related problems, the cost to provide affordable health care to employees continuously ranks as a top-tier challenge identified by employers in Wisconsin. With this in mind, the Coalition of Wisconsin Employer Groups Concerned about Health Care Costs, comprised of the organizations identified above, request state legislators understand the position of employers when contemplating AB 718/SB 753.

The payor organizations that have signed on to this memo urge your consideration of Wisconsin's employer and business community's perspective on AB 718/SB 753. The **passage of AB 718/SB 753 would remove an important tool that slows and even sometimes reduces health care costs for employers while maintaining quality health care for their employees and employee families.** AB 718/SB 753 would eliminate "white-bagging," a process health insurers have implemented to deliver clinically administered drugs directly to the clinic/patient when it is safe to do so. This practice is a necessary tool to address significant hospital mark-ups and keep medications reasonably affordable.

A recent study prepared for PhRMA found that, on average, hospitals charge 479% of their cost for drugs nationwide. Eighty-three percent of hospitals charge patients and insurers more than double their acquisition cost for medicine, marking-up the medicines 200% or more. Most hospitals (53%) markup medicines between 200-400%, on average. From our perspective, this trend is unsustainable. Specifically, health care prices in Wisconsin are some of the highest in the nation (see enclosed graph).

Give n the significant prices, employers and their employees are bearing the brunt of this on-going burden. For employers and Wisconsin economic development, t his translates into lower wages, fewer jobs and businesses looking elsewhere to grow their companies. Lawmakers who say they are concerned about jobs and the economy should be working with Wisconsin-based employers on health costs to ensure all options are available that result in a balanced health care marketplace for payors, providers, and patients equally and fairly.

Employers are committed to providing quality healthcare, but rising health care costs could jeopardize the affordability of employer-provided health care coverage for employees and their families. Ninety percent of plan sponsors said high drug prices are a threat.

As employer-based associations, we realize that perhaps some legislators that initially signed onto the legislation did not understand the relationship that exists between employer payors and health insurers and the fair and reasonable concerns we share. Given that, please afford Wisconsin businesses one less obstacle at a time when we are already overwhelmed with government mandated rules and regulations.

We sincerely appreciate your time and consideration with our concerns related to AB 718/SB 753.

Transmotion LLC
Bent Tubes LLC
Value Added Distributors
Gamber Johnson
Ameriquip
Marion Body Works
Great Lakes Veneer
K&S Manufacturing
Volm Companies
QPS Employment Group
Bassett Mechanical
Menasha Joint School District
MetalTek International
Trace-A-Matic
Kolbe Windows & Doors
Kwik Trip
OEM Fabricators Inc
Sandstone Group Inc
Lakeside Manufacturing Inc
Fond du Lac Area Businesses on Health
WI Counties Association Group Health Trust
Zero Zone, Inc.
Rice Lake School District
The Fall River Group
Altra Federal Credit Union
Seek Careers
Rice Lake Weighing Systems
Serigraph
hoffmaster Group, Inc.
Team Schierl Companies
Schierl Tire Service
Wysocki Family Companies
Enerquip
Midwest Carriers
P Prent Thermoforming
Create A Pack Foods
Colby Metal
Rite Hite Holding Corporation
E.C. Styberg Engineering
Putzmeister America, Inc.
The Boelter Companies
vjs Construction Services
Badger Mining
Walker Forge Inc.
Steinhafels Inc.
Plumbing Heating & Cooling Contractors of WI
WI Roofing Contractors Association
WI Paper Council
Wisconsin Independent Business Inc.
Midwest Food Products Assn.
The Alliance
WPMCA
WI Restaurant Association
WMC
All Metal Stamping
Colby Chrysler Center

Testimony Before the Senate Committee on Insurance, Licensing and Forestry
Koreen's Law – Senate Bill 753

Joanne Alig, Senior Vice President, Public Policy
Wisconsin Hospital Association

January 20, 2022

Madam Chair and members of the Senate Committee on Insurance, Licensing and Forestry. My name is Joanne Alig and I am the Senior Vice President of Public Policy for the Wisconsin Hospital Association (WHA). I am joined today by WHA's Board Chair, Mr. John Russell, CEO of Prairie Ridge Health in Columbus, Wisconsin and by Mr. Todd Nova, Attorney with Hall Render, whose expertise is in pharmacy practice matters.

I would like to thank you for the opportunity to testify in support of Senate Bill 753, known as Koreen's Law. One year ago, we were largely unaware of this issue of white bagging, and we certainly didn't anticipate that it would consume so much of our time and attention. Hospitals and health systems work with, negotiate with, and even partner with insurance companies on many issues. In Wisconsin, if there is conflict, most of those issues have historically been worked out between the two parties.

But there is growing trend by insurance companies to unilaterally, without negotiation, restrict patient access to their in-network medical care providers. In the case of white bagging, this is occurring at the worst time – when patients are trying to treat or manage life-altering conditions. This practice has now crossed the line, changing this issue from a dispute between two parties into a matter of consumer protection, patient safety and, thus, public policy.

This point bears repeating; we are here today because insurers are **single handedly using program changes outside of the contract negotiation process that serve to limit patient access to their medical care providers – their doctors, pharmacists and care team - that are already in their insurance network**. These decisions have negative consequences on patient safety, drug supply chain, cost, waste and administrative burden on patients and medical care providers.

This is happening both in the middle of the benefit year for their enrollees and in the middle of the contract with the health care provider or hospital. What happens then is that the health care provider's normal in-house pharmacy which is in-network for everything else is suddenly out of network for these particular medications. Sometimes the insurer will allow the pharmacy to remain in network but only if the health care provider or hospital agrees to the insurer's demand for a lower payment. These

decisions have negative consequences on patient safety, drug supply chain, cost, waste and administrative burden on patients and medical care providers.

It is important for the Committee to understand that Senate Bill 753 is not about all specialty drugs. It is solely about medications that a patient cannot administer to themselves. These aren't the prescription drugs you or I might go to our local pharmacy to pick up. These are medications or therapies that are administered by a clinician – a doctor, nurse, physician assistant - and typically are infused or injected intravenously. Patients receiving these treatments have life threatening diseases, or conditions that severely affect their quality of life: cancer, multiple sclerosis, rheumatoid or psoriatic arthritis, Crohn's disease, cerebral palsy and a host of other diseases for which these medications are a critical part of their overall treatment.

Health care providers typically buy clinician-administered drugs from wholesalers. They keep a stock on hand in the pharmacy or can obtain a needed drug for a patient within a short amount of time. The prescription medications in question are often costly and involve special handling and storage. For example, they must be kept at the appropriate temperature, light, and humidity in order to maintain their efficacy. The doctor, working directly with their patient, determines the best treatment for the patient. At the time of the patient's treatment appointment, the doctor and pharmacist can ensure the right medication is available, in the right dosage for the patient's needs.

Under white bagging, the insurer decides instead that the patient must use only the insurer's designated third-party or separate pharmacy for the medication the clinician will have to administer to the patient. The process where the insurer's separate pharmacy dispenses the drug for a particular patient and ships it to the hospital or physician's office where the clinician then is to administer the drug to the patient is called white bagging. The process where the insurer's third-party pharmacy mails a medication for a particular patient to the provider's office or pharmacy for administration to the patient is called white bagging.

The process of white bagging is certainly NOT the same as the hospital or physician office's normal process for buying, dispensing, preparing and administering clinician- administered medications. Compared to the normal process, white bagging requires the entire health care team - including the pharmacist, the doctor, nurses and other staff - to take on significant added workload and risk to provide needed care to their patients. And even with their extraordinary efforts, the process is so flawed that they can't always protect their patients from the negative outcomes of delayed treatments and higher costs.

Below are some of the real-world problems with these policies. Insurance companies state that there are always exceptions to their policies when problems arise and patient care is compromised, but our members' experience has found that if exceptions to white bagging exist, they are largely inaccessible to patients. As was the case with Koreen Holmes', who you will hear from today, patients and health care provider staff spend hours on the phone with insurance companies. Sometimes patients give up. When insurance company policies like white bagging fail, it is the medical care team and patient – not the insurance company call center employees - who are left to clean up this disruption in care.

Pharmacists and clinicians delivering care to patients have significant concerns about the safety of white bagged drugs

When hospitals and other health care providers control patient medications in-house, they can guarantee the point of origin of the drug and are responsible for and can demonstrate a clear chain of custody to ensure the medication remains safe and effective for treatment. White bagging, however, interrupts that process, disrupting a health care provider's ability to guarantee the safety of these drugs.

When issues arise, the provider has no leverage with the outside pharmacy to address concerns. The primary responsibility for patient safety remains with administering providers despite not having control over the quality and handling of drug therapies. This represents a significant liability to the provider even though they do not fully control the medication's preparation or delivery.

White bagging fails to deliver drugs to patients when they need them and increases patient confusion

Ultimately, patient safety is not measured just in using an appropriately handled drug, but also timely administration of their medication. White bagging has resulted in numerous instances of delays in patient care. When patients with conditions such as cancer or multiple sclerosis have treatment delays, their quality of life is jeopardized.

Treatment can be delayed under a white bagging process for several reasons:

- ✓ the medication doesn't arrive on time
- ✓ the product delivered is no longer correct given changes in the patient's treatment;
- ✓ the product delivered is an inappropriate or wrong dose; or
- ✓ the product delivered can be damaged.

White bagging increases administrative burdens and shifts costs to providers

When insurers require drugs to be obtained through a white bagging process, hospitals and other health care providers incur significant added costs and administrative burdens that are not contemplated nor incorporated in any cost-savings analysis conducted by payers. Not only do many of the drugs still require added handling by a licensed health care professional before administration to the patient, but additional operational issues identified by providers in Wisconsin include the need to:

- ✓ hire staff to handle the logistics of the entire white bagging process;
- ✓ add space and refrigeration specifically for these medications;
- ✓ implement a new inventory management system; and
- ✓ develop new processes to handle medication waste that results when the medication for a patient cannot be used due to updates in treatment regimens or dosage needs.

Patients may actually incur greater out-of-pocket costs for white bagged medications.

With white-bagged drugs, the patient now must coordinate with a third-party pharmacy to receive care. Patients can end up paying more in copayments as the costs are shifted to their pharmacy benefit, or if their provider does not accept white bagged medications, the patient pays the full out-of-network cost, even though their health care provider is actually in the insurer's network. As a result, white bagging does not save money for patients in these situations.

Insurer's will say that hospitals mark-up drugs significantly and that's why they need to white bag drugs.

First, there seems to be an impression that hospitals can just unilaterally mark up the price of a drug whenever they want. The reality is that these are prices that are negotiated with the insurance company. In this instance of white bagging, it is the insurer that is unilaterally demanding a lower price or keeping the pharmacy out of network for these drugs.

Second, with white bagging, the costs to the physician's office or hospital do not go away. The infrastructure to handle the medications still needs to function, and with white bagging arguably at even greater cost. And white bagging also then adds the resulting risk of harm to patients.

Further, some studies pointed to by insurance companies suggest that reimbursement for treatment should match the drug acquisition cost. That is neither reasonable nor sustainable. Preparation and administration of these complicated therapies incurs significant expenditures of time, equipment and labor capacity of highly trained professionals. In fact, one of the studies insurers point even acknowledges that the difference in price between hospital and nonhospital settings for some cancer drugs may actually have to do with these costs.

What hospitals are able to accept in a contract for providing a service needs to not only account for the cost of delivering that care, but also to make services available to anyone, at any time of any day. Without hospitals, these services, and many others, simply would not exist in your communities. This is why determinations of appropriate rates belong in the contract, where a conversation can be had between employers, payers and providers about what is necessary to maintain a high quality health care infrastructure that is needed in Wisconsin communities.

But most importantly, SB 753 itself is clear that the applicable reimbursement rate for clinician-administered medications is the rate specified in the contract. The insurer might not be happy with the negotiation they conducted. But the reimbursement rate should be addressed through the contract negotiation process, instead of through policies that reside outside of the contract, interrupt the provider supply chain, and endanger patient safety.

Other provisions in the bill:

Brown Bagging: We also strongly support SB 753's prohibition on brown bagging. Brown bagging, when medications are sent to the patient's home first, is an even more egregious practice as it is asking the provider to insert into a patient's body a substance that the health care provider cannot verify what it is, much less whether it has been safely stored and handled.

Home Infusion: The decision to administer medications in the home setting can be a good option for some patients. However, that decision should be made in cooperation with the patient's doctor. Some insurers are not only offering home infusion, but are requiring it. Whether home infusion is suitable and safe for a patient should be up to the patient and their doctor, not the insurance company.

Other aspects of SB 753 related to utilization management: Prior authorization, medical necessity denials, care restrictions - these tools are being used increasingly by insurance companies simply to deny care. Limiting insurance company use of these tools in the instance of clinician administered medications simply closes loopholes that insurers would otherwise use to get around the intent of this legislation's prohibition on white bagging, brown bagging and mandatory home infusion.

Members of this committee have previously expressed support of the exact issues that are at the very core of Senate Bill 753. A primary argument used to support passage of PBM legislation earlier this session was that decisions about prescription medication regimens should be made between a prescriber and their patients and that patients should not be at-risk of losing access to drugs. We agree.

We are asking the Committee to apply that same policy position in support of Senate Bill 753. We are asking that you take patients out of this process and ensure that these complicated issues are dealt with through contract negotiations between providers and insurance companies, not by patients.

Thank you for your time and attention to my testimony.

Testimony before the Senate Committee on Insurance, Licensing and Forestry
2021 Senate Bill 753 – "Koreen's Law"
January 20, 2022
John Russell, CEO – Prairie Ridge Health

Committee Members,

Good morning, I'm John Russell, CEO at Prairie Ridge Health a rural critical access hospital in Columbus Wisconsin. Thank you for the opportunity to testify in support of Senate Bill 753.

I just want to start with a thank you to Senator Jagler for his past support for the hospitals and patients in his district. Senator Jagler took time to attend a meeting at Prairie Ridge Health, in September of last year, to discuss the impact of White Bagging. There were a number of rural hospitals represented and other legislators present. Senator, thank you for always taking time to listen. You are a class act.

Health Care is complicated. I think it is fair to say that when a patient needs an expensive infusion, it is likely one of the most difficult times in their life. Hospitals and health systems work with patients to coordinate their care, ensuring patients receive the right medications at the right time in a convenient location during a difficult time in their life.

As a rural community hospital, access to care for our patients is always a priority. Driving long distances for infusions is a hardship for patients. They generally need multiple treatments at a time when they really don't feel well. These are regular people like any one of us here in this room. They have jobs, families, and busy lives. Receiving care, a long way from home costs money, time away from work, and time away from families. The health insurance companies have already charged these patients premiums for their coverage. Then when they need coordinated, local care the most, they are asking them to seek that care outside their community and away from their trusted care team.

Coordination of a patient's care is one of the more important roles a provider plays. We know these people personally. We know their health history and we know their needs. We are an important part of their support system during an extremely difficult time. I believe people need people when they are sick. They need support and understanding. Instead, with White Bagging, they are spending time on the phone attempting to navigate a complex health insurance system. This shouldn't need be a patient's top priority during these difficult times. Their health should be their priority and their focus.

White Bagging represents a fundamental shift in the relationship between patients, hospitals, and insurance companies. Up until now we have agreed providing high quality, coordinated, early treatment is the best care for the patient and in the end will reduce expense. White Bagging appears to be more about reducing costs for the insurance company than quality patient care. This practice takes the patient's trusted clinical care team out of the role of coordinating their care and instead places this burden on the patient. In addition, it greatly increases the risk of providing the wrong treatment at the wrong time. This is a bad precedent!

I think it's important to note that coordination of care has been universally accepted as a way to improve health outcomes and in the end reduce costs. Taking the provider out of this equation may save money up front, but fragmentation of care ultimately leads to poor outcomes and more cost on the back end. Insurance companies have been a part of this focus on coordinated care in the industry. White Bagging is a clear departure from this focus and in the end will lead to bad patient outcomes!

This practice has just recently begun. If it is allowed to continue, we will see even more patient harm. Delays in care can be difficult to quantify,

but it is clear delays in care do cause harm. We already have direct examples of breaks in supply chain custody resulting in improper storage and incorrect dosages received and flagged by hospitals. These have already resulted in quantifiable direct patient harm or near misses. Please don't let this practice continue!

Thank you again for the opportunity to testify.

Testimony before the Senate Committee on Insurance, Licensing and Forestry

2021 Senate Bill 753 – "Koreen's Law"
January 20, 2022

Todd Nova - Shareholder
Hall, Render, Killian, Heath & Lyman, PC

Introduction

Chairwoman Felzkowski and members of the Senate Committee on Insurance, Licensing and Forestry. My name is Todd Nova, and I am a Shareholder with the law firm of Hall Render based in our Milwaukee Office. Our firm focuses solely on health law issues nation-wide. My legal practice focuses on health law issues for health care providers across the country including integrated health care systems, pharmacies (comprised of retail, specialty and institutional types), hospitals, health care group purchasing organizations and provider clinic organizations.

These issues include those affecting the sourcing, delivery, dispensing and reimbursement of pharmaceuticals. I routinely speak, write and advise clients nationally on related state and federal pharmacy practice matters, government payor issues, false claims and anti-kickback laws, collaborative practice models, health care licensing, distribution and sourcing agreements (group and direct purchasing), private payor issues and the 340B drug discount program. My work also includes advising providers responsible for caring for underserved and rural populations.

I am honored to be joined by Ms. Joanne Alig, WHA's Senior Vice President of Public Policy and Mr. John Russell, WHA's Board Chair and CEO of Prairie Ridge Health in Columbus, Wisconsin. The WHA team asked that I share with the Committee core legal considerations that Koreen's law is intended to address.

My testimony today will therefore address four key areas implicated by insurer-mandated white bagging models. These include: i) legal risks to front line pharmacists and providers arising out of the manipulation of already-dispensed drugs; ii) common drug reimbursement misconceptions; iii) distinctions between non-profit healthcare providers and for-profit health plans; and iv) the role of hospitals as safety net and emergency services providers.

Legal Risks to Front Line Pharmacists and Providers Associated with Manipulation of Already-Dispensed Drugs

As you have already heard, the white bagging model requires significant pharmacy and pharmacist involvement for safe drug handling, preparation and administration. The model, however, only allows for technical component or "administration fee" reimbursement to the hospital. Ingredient cost reimbursement is not available to the receiving hospital. Instead, a dispensing pharmacy that often has a financial relationship with the mandating payor retains dispensing fee and ingredient cost reimbursement.

In spite of what you may have heard, white bagging does not reduce the need for hospital pharmacy and pharmacist oversight. In fact, it increases administrative burdens and implicates key legal risks placing managing pharmacists in the position of having to carefully monitor an institutional process dictated by a third party. More, that third party (the insurer) is insulated from direct oversight by our state agencies including DHS and Board of Pharmacy relative to the hospital's pharmacy license.

Among other issues, hospital electronic medical records do not have baseline functionality that allows for the automated scanning, tracking and billing of white bagged drugs. For pharmacists who are professionally responsible for the administration of safe, unadulterated drugs, this results in a massive administrative and ultimately personal burden.

From a legal perspective, manipulation of a dispensed prescription may only be performed in accordance with FDA-approved labeling instructions. That is, if mandated white bagging requires any non-standard

manipulation such as a dosage modification, it could be construed to be impermissible wholesale distribution rather than allowable patient-specific dispensing. Given the complex nature of the conditions typically treated in the hospital setting, it is not uncommon for such manipulation to be required.

The distinction between a drug that has been dispensed for a particular patient and one that has been distributed to a pharmacy for further patient-specific manipulation and subsequent dispensing is relevant. It is illegal in Wisconsin (and all states, really) for a pharmacy to receive, process and then re-dispense a patient-specific drug since the drug would not have been received via a permitted wholesale distributor.

To be clear, delivery of a patient-specific drug that only requires reconstitution or manipulation consistent with FDA-approved labeling would not constitute a prohibited "distribution" in contravention of state and federal law. In that instance, the receiving institutional pharmacy would simply be viewed as the patient's agent for receipt. While this raises fundamental fairness concerns relative to appropriate reimbursement given the operational efficiency considerations noted above, it would not be legally impermissible.

While this may seem straightforward to a layperson, determining whether or not manipulation of a drug is consistent with FDA-approved labeling is not easy. Rather, it is a labor-intensive undertaking that must be carried out at the drug-specific level. Plainly stated, the task is simply not supported by current care delivery models and technologies. This introduces unnecessary risk into the care delivery system and places a significant burden on hospital pharmacists to ensure compliance with detailed FDA labeling requirements. As such, while white bagging has been positioned as a cost-savings mechanism, at best it serves to increase complexity and costs. At worst, it serves to increase risk of patient harm due to the required implementation of non-standard processes unsupported by current institutional information technology infrastructure.

Consider as an example a white bagged drug product received from a specialty pharmacy that is accompanied by FDA-approved directions describing the mixing, reconstitution, or other actions necessary to prepare the drug for administration. This would not be impermissible. These drugs might include a finished drug product with FDA-approved instructions that state the name of the drug, the amount of diluent that must be added to facilitate reconstitution, the type of diluent required (*e.g.,* 0.9% saline), the total resulting volume of the solution, the concentration of the resulting solution, and the expiration date of the solution once mixed. Sounds complicated, doesn't it? Well, it is. In addition, all of these activities must be performed using appropriate sterile procedures as required by state and federal law. The proper implementation of sterile procedures for injectable drugs requires material technical training, which is why it should only be conducted as part of the practice of pharmacy or medicine. Many payors do not appropriately recognize the cost of these activities.

Pursuant to the Wisconsin Pharmacy Practice Act, prohibited "unprofessional conduct" includes a failure to comply with applicable federal and state law related to safe sterile procedure. This means that hospital pharmacies must prepare these drugs very carefully, typically under the supervision of a licensed pharmacist, just as they would with a typical dispense. However, for white bagged drugs, the reimbursement is significantly reduced based on the false premise that the drug has already been "dispensed."

Compliance with sterile procedures and other core competencies associated with the practice of pharmacy is a high bar that is not lowered by the practice of white bagging. In fact, the practice increases complexity and diverts limited resources away from the provision of patient care. Additionally, white

bagging ultimately puts our front-line pharmacists in the unenviable position of having to micromanage a process that creates tremendous risk without giving them the appropriate tools and resources to do so.

Common Drug Reimbursement Misconceptions

As you likely know, certain key affinity groups argue that hospitals are charging very high amounts that result in massive profit margins at the expense of patients directly and indirectly through increased copayments and payor costs. If these drugs were actually reimbursed at these rates, this might be a compelling argument. However, they are not.

While drug reimbursement methodologies depend on the age of the agreement, many older contracts pay based on a percentage of charges. Even then, it is only a limited percentage of charges and very rarely one hundred percent.

More recently, there has been a lot of pressure to move beyond charge-based methodologies and payers are pushing to implement either a standard negotiated fee schedule or bundling drugs into a grouped global rate. For example, it is increasingly common for payers to implement payment schedules based on a percentage of Medicare reimbursement or a discount off of Average Wholesale Price or "AWP-%." As a result, chargemaster amounts have less and less to do with actual drug reimbursement. Suggesting that charges are equivalent to reimbursement is at best an incomplete description and inappropriately redirects the dialogue surrounding this issue.

Distinguishing Between Non-Profits, Healthcare Providers and For-Profit Health Plans

I would also like to point out that the overwhelming majority of Wisconsin hospitals are tax-exempt, non-profit entities. This distinction naturally creates different incentives as compared to for-profit entities and results in fundamentally different allocation and utilization of resources.

For those curious about how revenues are allocated or spent, exempt hospital organizations must submit annually an IRS Form 990 to detail the activities and policies of, and community benefit provided by, its hospital facilities and other non-hospital health care facilities that it operated during the tax year.

These filings require the disclosure of charity care expenses, community building efforts, bad debt expenses, organizational structure and facility information. As others today can attest, these filings detail for all to see the vital resources hospitals provide to our communities. Among other resources, a review of virtually any Wisconsin hospital's Form 990 would illustrate the vital safety net emergency and COVID-related services provided. Even if prescription drug revenues support these non-profit missions, reallocating those amounts to for-profit institutions via white bagging would further diminish the emergency response resources upon which our communities clearly rely, and which are provided solely by our state's hospitals.

Also, unlike for-profit payors, a material portion of hospital revenues enable availability of emergency department services irrespective of a patient's ability to pay. Though already a part of the organic mission of our hospitals, this is also required by law. This means that this commitment to front line emergency services is assured in its longevity.

Specifically, Congress enacted the Emergency Medical Treatment & Labor Act ("EMTALA") to ensure public access to emergency services regardless of ability to pay. That law imposes specific obligations on

Medicare-participating hospitals that offer emergency services to provide treatment for emergency medical conditions regardless of an individual's ability to pay.

Compliance with EMTALA requirements is, in part, funded by revenues from all hospital operations which obviously include prescription drug revenues. To demonize margin on any aspect of care provided, including prescription drugs, is unfair and diminishes the importance of ensuring continued availability of services in our communities. In reality, some white bagging models serve to divert drug revenues funded by patients to for-profit, payor-owned pharmacies with no IRS community benefit or EMTALA-related requirements.

Moreover, white bagging requirements in certain circumstances could frustrate a hospital's ability to comply with their EMTALA obligations if, for example, they were required to assess whether or not drug coverage is available.

Conclusion

When read together, mandatory white bagging rules: i) create legal and operational risks for our front-line pharmacists; ii) rely on common drug reimbursement misconceptions for legitimacy; iii) fail to distinguish between non-profit healthcare providers and for-profit health plans; and iv) ignore the role of hospitals as safety net and emergency services providers.

This proposed law is cognizant of the fact that white bagging can be appropriate in limited circumstances. However, the issue is the promulgation of unilateral and broad-based white bagging requirements that create patient risk, divert scarce pharmacist resources, increase costs, limit access to care and shift savings to for-profit entities not required by law to provide care to our Wisconsin communities.

The continued availability of health care access in our underserved communities, whether rural or urban, is being severely impacted. We therefore respectfully request your support of Senate Bill 753.

Wisconsin Association of Health Plans

Senate Bill 753
Senate Committee on Insurance, Licensing and Forestry
January 20, 2022

Chair Felzkowski, Members of the Committee, thank you for the opportunity to testify today. My name is Tim Lundquist and I am the Senior Director of Government and Public Affairs at the Wisconsin Association of Health Plans. The Association is the voice of 12 community-based health plans that serve employers and individuals across the state in a variety of commercial health insurance markets. I am joined by Pat Cory, PharmD, who is the Pharmacy Director at Quartz, a community-based health plan with offices in Madison, Sauk City, and Onalaska.

Pat will speak about Quartz's perspective on issues related to clinician-administered drugs, but I would first like to provide a few comments on behalf of the entire Association.

First, the Wisconsin Association of Health Plans is opposed to Senate Bill 753 because the legislation removes nearly every existing tool health insurance providers have to encourage lower cost, higher quality, and more convenient drug administration. This bill has implications far beyond white bagging—which is why some health insurers, even if they are not currently engaging in some of the practices under discussion today—are so concerned about this legislation. This bill directly asks this committee to decide whether white bagging and other payer strategies used to combat the growing cost of clinician-administered drugs should be permitted to continue in Wisconsin. But the breadth and complexity of this bill implicitly ask this committee to answer many other important questions: Is it appropriate that this legislation creates a special class of drugs that are to be administered and paid for unlike any other medical service, prescription drug, or medical device? Should this legislation toss aside every medical management tool currently used by health insurers for a rapidly growing class of high-cost specialty drugs? Is this the approach Wisconsin should take if we are collectively interested in ensuring patients receive high-quality, evidence-based care? Does this legislation help Wisconsin patients, families, and employers who already struggle with high prescription drug costs better afford the care they need?

Second, Association member health plans take different approaches to the purchase and administration of clinician-administered drugs. Some member health plans have a white bagging program, while other member health plans do not. Some member health plans use white bagging for a subset of high-cost, specialty drugs, while others use this strategy for a more limited set of drugs and only at the request of providers. However, while Association member health plans may vary in the extent to which they use white bagging as a tool to safely manage the high cost of clinician-administered drugs, there is one practice that does not vary: every insurer with a white bagging program has an exception process in place to prevent the disruption of patient care. It is in everyone's interest—including a health plan—to ensure that patients have timely, safe access to the treatments they need.

Finally, this impact of this proposed legislation does not start and end with health insurers. Employers and employees ultimately bear the high cost of clinician-administered drugs through higher health insurance premiums and out-of-pocket costs. Community-based health plans are committed to ensuring their members continue to have access to the right care, at the right time, and at a price they can afford. We respectfully ask the committee to not take away tools many health insurers, and more importantly, their customers, use to try and achieve these important goals.

Quartz

TO: **Members of the Senate Insurance, Licensing and Forestry committee**

FROM: **Jonathan Moody, Director of Government Affairs**
Pat Cory, PharmD, Pharmacy Director

DATE: **1/20/2022**

RE: **Written Testimony Opposing Senate Bill 753 – Prohibiting certain practices relating to insurance coverage of clinician-administered drugs**

Chairwoman Felzkowski, Vice-Chair Stafsholt and members of the Insurance, Licensing and Forestry committee:

Quartz is a health plan management company co-owned by four nationally recognized integrated health care delivery systems – University of Wisconsin Health System, Gundersen Health System, Unity-Point Health Meriter and Advocate Aurora Health. Quartz provides health plan coverage for more than 360,000 members across Wisconsin through our Medicare Advantage, Medicare Supplement, Medicaid Managed Care, and Commercial lines of business (including Qualified Health Plans and State of Wisconsin Group Health Insurance Program).

At Quartz, our goal is to help members achieve the best possible health outcomes and live life to the fullest. To achieve this, we offer comprehensive benefits and services at an affordable price and partner with the highest-quality providers.

Quartz opposes Senate Bill 753. Not only does this legislation prohibit the practice often referred to as "white bagging," which is used very rarely by Quartz but has been instrumental in our efforts to secure fair reimbursement terms on high-cost specialty clinician administered drugs but SB 753 goes significantly further, eroding some of the most fundamental features of managed care – formulary management, evidence-based medical management tools like prior authorization and medical necessity review, provider network management and benefit design (including the use of financial incentives that reduce member out-of-pocket costs for using Quartz's highest quality, lowest cost providers) – that help ensure the health and safety of our members and provide cost containment tools that are essential to keep comprehensive health care coverage affordable.

As this committee understands well, a primary obstacle to comprehensive health care coverage is affordability. Studies, opinion polls and experience confirm the correlation between the rising cost of health care and actions by consumers and patients to defer medical care or forgo coverage altogether.

While there are many factors that contribute to rising costs of health care, spending on high-cost specialty clinician administered drugs has emerged in recent years as one of the primary drivers of heath care spending. These specially drugs, which are typically biologics that treat rare indications and auto-immune diseases, are used by a small subset of Quartz's membership but account for tens of millions of dollars in healthcare spending annually. The growing spending on these drugs is unsustainable and puts significant upward pressure on member premiums and threatens the affordability of high-quality healthcare coverage for tens of thousands of individuals and families across Wisconsin. Therefore, reducing the cost associated with these high-cost drugs is an effective approach to reducing a significant, and growing, obstacle to comprehensive health care coverage.

With the growing pipeline of new gene therapies, approval of existing specialty medications for new indications, skyrocketing drug list prices, and significant markups over acquisition cost by some provider groups, it is more important than ever that Quartz pursue comprehensive cost control strategies. Quartz is fully invested in the health, safety, experience, and total well-being of our members. We pursue policies and take actions that are evidence-based, member-centered, clinically appropriate, and financially responsible. We work closely with all our provider partners and value the critically important role they play in providing high-quality care for our members.

Pat Cory, PharmD, Quartz's Director of Pharmacy, will provide testimony to the committee that describes the cost of these specialty clinician administered drugs and describes in detail the actions Quartz is taking to reduce cost of these drugs while providing the highest standard of care to our members.

It is important for the committee to know the savings achieved by the efforts described in Quartz's testimony are returned to our members and employer groups in the form of reduced premiums and lower out-of-pocket costs. Business and employer groups across Wisconsin recognize the importance of these tools in bending the health care cost curve. The growing coalition of Wisconsin employer groups, some of whom will testify before this committee, support health plan practices that protect patient safety and deliver cost savings that allow them to continue to offer employer sponsored coverage to employees and their families.

If passed, this legislation would have significant negative impact on member premiums, cause some employers to drop employer sponsored coverage, and ultimately, increase (not decrease) barriers to the important services the bill purports to protect.

We respectfully request this committee carefully evaluate the full scope of SB 753 and consider the impact to health care consumer costs and access to comprehensive health care coverage in Wisconsin.

Quartz will continue to work with the large and diverse coalition opposing this legislation and pursue policies that allow us to continue to offer comprehensive coverage, and affordable access to these high-cost specialty clinician administered drugs while achieving the best possible clinical outcomes for our members.

Thank you for considering the perspectives offered in our written and in-person testimony. I welcome the opportunity to discuss this legislation in more detail or answer any questions you may have about the harmful impacts of this bill on Quartz's members and employer group customers.

Sincerely,

Jonathan Moody

Quartz

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STATE REPRESENTATIVE
JESSE JAMES

January 20th, 2022

Testimony of Representative James in favor of SB 753

I want to thank Chairwoman Felzkowski and other committee members for hearing this bill, which we will hopefully call "Koreen's Law" one day. I am thankful for this opportunity to be here today and share some information with you.

In these types of situations where there are obviously competing interests, I love the fact that we can all come together and work to solve issues. It's one of the reasons why I love being a legislator. This issue of "white bagging" obviously impacts many different entities: employers, businesses, insurers, pharmacies, hospitals, and patients. When we first started the discussion over this issue, I asked myself if it was possible to come to the table, negotiate, compromise, and come to a resolution that would satisfy everyone involved. But what exactly would this look like? For me, personally, I wanted to look out for the best interests of our patients, the ones experiencing these hardships and who, most likely, cannot afford the predicament they are facing.

Koreen was and is one of these patients. Every three weeks, Koreen was receiving life-saving infusions. She started her treatment in February, had her care team, her rapport, relationships, family, and support structures in place. Five-months later, her road to recovery was interrupted when her health insurance company put a new policy in place dictating where the hospital could obtain her medication, a tactic known as "white bagging."

My heart goes out to Koreen, Nate, and her family for what she has gone through. It is my belief that once treatment has started for someone with cancer or any other of these serious illnesses that require such involved care, that treatment should not be interrupted unless it is a life issue, not a money issue.

Information taken from an article in the *Leader Telegram* dated October 25, 2021 states:

Some hospitals have policy of not using medications from outside sources, like Sacred Heart in Eau Claire. This impacted Koreen's treatment and everything she had in place for her and her family.

This is what concerned me most. I ended up asking myself, "why would this happen?" The only answer I could think of is, as it always seems to be, MONEY! Why else would insurance companies change things mid-stream? Why would they force patients to go to another treatment center? Why would they make changes to the hospital and care team a patient already established? Why would we complicate patient care and introduce complications? These are the answers our citizens of Wisconsin want. This is why I support Koreen, Nate, and so many others. This is why I support Koreen's Law.

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Phone (608) 266-9172 • Toll Free (888) 534-0068 • Rep.James@legis.wisconsin.gov

Madam chair and members of the senate committee on insurance, licensing and forestry, thank you for allowing us the opportunity to testify in support of senate bill 753. My name is Koreen Holmes and this is my husband Nate. ~~This is~~ incredibly important to me for many reasons. I've never had an experience like this before and after being asked to share my story it was an absolute yes. It angered me, frustrated me and most importantly it hurts me knowing that it didn't just happen to me personally but its happening to others as well. ~~The white bagging policy instituted by insurance companies has majorly impacted my lie and the life of my family. There wasn't a doubt in my mind to lend my name to~~ a ~~legislation that will hopefully ban this horrid~~ practice.

This is my story.

At 31 years old and 36 weeks pregnant with a 2 year old daughter I was diagnosed with stage 3 TNBC. January 27th I went into the hospital and the 28th we delivered a healthy beautiful baby boy. The following week I underwent multiple scans and then that Wednesday I started treatment. 6 months of chemo, a single mastectomy in August followed up with 30 rounds of radiation in Madison.

TNBC means there's not a lot of treatment options for me so receiving my recommended treatment is crucial for the success of my long term outcome. Keytruda, a newer ~~drug~~ immunotherapy, is basically a tn patients lifeline. September 3rd 2021 I received a call from my cancer center. Not insurance. I spent 2 hours on the phone with a lady from insurance who had no idea what I was talking about or

They told me a brief description about this new policy & how I need to call insurance to ask for an extension.

what white bagging even meant. She expected me to tell her about this new policy that I wasn't even aware of. ~~How frustrating!~~ I spent 2 hours on the phone crying, frustrated and ~~so~~ stressed out. ~~2 hours. What cancer patient should have to go through this? This isn't my job to figure out how to continue my treatment!~~

as a patient it shouldn't be extremely my job to help the insurance company figure out what I am talking about when I don't even know myself.

NO patient, regardless of their ~~disease~~ condition, should go through this.

The insurance company had said that they tried contacting me but that wasn't true. Not once did I receive a call, email or letter from them and not once during the entire duration of this ~~entire~~ ordeal did I ever get any form of communication from them.

The insurance companies say we have expectations but that's not valid. The lady at the insurance company had said shed help me do anything she could to continue my care and that she would call me back. I never got a call from her so I called her the following week. She said she remembered me and was still trying to figure this out and would again call me back. Never did. In fact I didn't hear from anyone except my care team about this until my team reached out to me in October saying I needed to get ahold of my insurance company because there was nothing else they could do for me and I was getting denied.

I was in Madison at this time getting radiation and there was nothing I could do. Panicked I called my husband who was in a work meeting and left a message bawling about how he needed to drop everything he was doing and help me out. ~~Keytruda is a drug~~ the treatment I recieved that I have to get every 3 weeks and I was approaching my next treatment date so this was a deadline for me.

is done

What I don't understand and still don't understand was how they were okay with this. Not only am I a mom and wife but im a daughter, sister and a young cancer patient fighting for my life. And I'm just one person – how many others are there?

I have been with my team since January 2021 and they know me. Think~~ing~~ about leaving them or going x amount of miles to maybe or maybe not get my treatment. As a ~~cancer~~ patient its crucial you have faith and trust in your team and that's exactly what my team has given me. ~~That's exactly what HSHS is for me~~ – they became my family.

there was a point where I had to

gave me.

that was scary, frustrating & unfair. Not only would I have to possibly drain savings account

UK file for bankruptcy if I was denied but now I have to think about child care, where i'd stay, uprooting my life, ~~cancer~~ x finding a treatment center ~~in Toronto~~. that would take me in a quick amount of time.

basically

This last yr was already hard on my family but especially my daughter. Thinking about putting her through more hurt my heart.

Conclusion –

Im asking you all to please support Koreens law. This law I believe is crucial and in fact life saving and you have the opportunity to help stop this and prevent others from going through what Ive

been through or worse. Fighting cancer is scary .... Its life or death. I'm thankful I can say that I beat this but will the next person be able to say the same thing because of something like this happening to them?? Because their medications got delayed or something worse?? As someone who had to ~~first hand~~ experience this its very real. Thank you for your time.

firsthand

also much

Nate: Introduction

1st Senate Committee Members, we are here today to inform you about why this legislation is so important to us. We have never testified in support of a proposed law, or even imagined we would do such a thing, but I hope sharing our story and our experiences within the last year - not only battling cancer - but, also battling the new white bagging practice, helps you understand why it shouldn't be allowed.

This was an extremely tough time for our family - fighting a cancer battle, Welcoming a second child, and being the primary provider for our family. I am in a commission only sales position which financially is a burden in itself. All of a sudden we are faced with a barrier that comes out of nowhere and leaves us navigating and becoming our own advocates. Essentially, we started fighting for my wife's life - let me take you through my experience first hand.

I received a voicemail from Koreen while I was at work one day. Unfortunately I was in a meeting and wasn't able to answer my phone. There's nothing worse than getting a voicemail from your wife who is bawling and in complete distraught telling me I needed to drop everything from work and help her out immediately!

I made a call to our careteam the next day.

I met with Jess, and other hospital staff early on a Friday morning in Oct. When I arrived, i wasn't sure how my role in this would influence the way that Koreen would receive her on going treatment however, I was prepared to fight for my wife and her life. By what ever means necessary.

I called the 800# on the back of my insurance card. And we were listening to the phone tree with hope to hear a prompt to speak to someone about this new white bagging policy. I was very much confused as to what this meant for us, why we no longer could get the treatment that had already been fully approved at the beginning

of the year. This disruption came out of nowhere in the middle of Koreens treatment and we were closing in on her next apt. We remained on the line and talked to the first available representative. Asking to speak to someone about white bagging and asking to be granted a " CONTINUITY OF CARE". This was the first time i had heard about asking for this... I explained in full detail as best as I could what we were calling about. I explained that my wife had been undergoing treatment for triple negative breast cancer with the immunotherapy treatment called keytruda. The representative did not have any idea what we were talking about or asking for. However they transferred us to a different representative who were told would be more helpful. This then began the whole story, and process over each time with each new representative. As you can imagine we were continually more and more frustrated and disappointed with each transfer. And I would tell my whole story over from the beginning. We were transferred 6 different times, and exhausted a full 6 hours on the phone. Being sent around & around on a goose chase.

Even after all of this... we were still unsuccessful. As the day went on, it felt as if we were at a loss, completely unheard and countlessly misunderstood. There became a point where the staff members and I talked about seeking a new treatment facility and new care team. And at one point I had called Koreen and we had to discuss the possibility of draining our savings account or even worse filing for bankruptcy in order to stay with our care team. IT was 3:30 on a Friday afternoon, When finally we had received notice that a continuity of care was granted for 90 days. We were ecstatic, celebrating, and although we achieved the outcome we were seeking I can't explain how much stress, worry, and anxiety was riding on this day. To think about what others who maybe don't have a care team or have a voice in the matter go through is devastating & No one should ever experience this.

As a health care customer we only know to receive treatment & medication from the hospital.

Jess Conclusion –

Nate: Conclusion I ask that you...
Please support Senate Bill 753 to protect patients like my wife, Koreen, your constituents, and possibly you or someone you love . Unfortunately, There are already many stories like ours across Wisconsin. If you do nothing to stop this, there will be many more and not all of them may have the positive outcomes ours did and could be at the expense of someone's life. Thank you

Then Koreen Conclude

Savings
money is never as important than someones life.

Koreen – Intro/story

Nate – story

(...thinking of others who may not have support of care team is devastating)

Jess -

Good ~~morning~~ afternoon Chairwoman Felzkowski and Senators, Thank you for taking time to hear my testimony supporting Koreen's Law. My name is Jessica Gugel. I am a nurse navigator at the HSHS Prevea Cancer Center in Eau Claire. As a health care provider, ~~we seek a lifelong career in this field with the motivation~~ I am motivated by a strong desire to help the patients we serve. I met Koreen and Nate almost exactly 1 year ago. I am so happy to be ~~standing~~ here with them now that Koreen has completed her treatment and is back to living life!

As a nurse navigator, my role is to build trusting relationships between patients and the care team, reduce or eliminate barriers to care, and advocate for patients. I don't think I ever thought that would mean testifying before a senate committee, but here I am, because this issue is so important.

A cancer diagnosis is extremely stressful for patients and their families. Having faith in the care team can help alleviate much of this stress since providers and patients work together to design each step of the care plan down to the finest details.

Policies such as white ~~or brown~~ bagging are not good for patients. These policies take medical decision making and treatment planning out of the hands of patients and caregivers. They are disruptive to the care plan and can lead to disjointed, delayed, and possibly even unsafe care. These policies can lead to patients missing, delaying, or forgoing treatment all together. We are talking about treatment that is so important for patients, especially patients like Koreen, with high risk disease. Patients who have so much to live for, like their young children.

Additionally, patient safety cannot be overlooked. These policies are prone to a host of problems including shipping delays, delivery errors, and patient-specific factors that may require dosing changes. Typically, these medications are mixed

Jocelyn - ⊕ exemption + surgical [illegible]
CCU RN

Carol - [illegible] of white [illegible]
CNA VA home

Charles - transferred care

Greg

Natasha - - transferred care

"just-in-time" on the day of treatment to allow for dosing adjustments related to changes in a patient's weight or to ~~reduce~~ toxicities. The hospital pharmacy keeps these medications on the shelf. They are ordered and follow a strict chain of custody to ensure proper storage and handling. White and brown bagging policies cannot ensure the medications don't sit on a dock somewhere in the heat or cold, or end up delivered to a wrong location. All of these examples can cause delays in treatment. Treatment delays not only result in sub-optimal care and outcomes, but also add to the stress and fear of patients wondering if a delay will cause their cancer to grow, spread, or come back.

These policies add so much stress and anxiety to an already extremely taxing situation. The tears and frustration are very real. The hours spent trying to understand what is happening and why are exhausting. This high level stress impacts patient outcomes and quality of life. Fortunately, Koreen and Nate, were extremely engaged in her care and have truly been their own best advocates. But the healthcare system is complex, and even with our help, days were spent by Koreen, Nate, myself, and several other office staff trying to appeal the insurance company's new policy. When this much time is spent helping one patient, others may not be getting the time and attention they need.

For these policies to impact even one patient, it is too many. Please support Senate Bill 753 so I can continue to help people who need my care. It is devastating to see the look on a patient's face when we explain the white bagging policy to them – and tell them our hospital won't, for their safety, practice white bagging.

Our team is there to provide excellent care, our hospital pharmacy is integrated with our cancer center and the medications are on the shelf – and we know they are safe because we've purchased, tracked and traced them – but if we can't administer those medications, because they're not from an insurer's specialty pharmacy – we are risking ~~positive~~ outcomes for our patients.

Nate – conclusion

Koreen - conclusion

HSHS WISCONSIN

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Testimony before the Senate Committee on Insurance, Licensing and Forestry
2021 Senate Bill 753 – "Koreen's Law"
January 20, 2022

Andy Bagnall, President and CEO
HSHS Wisconsin

HSHS WISCONSIN

Chairwoman Felzkowski and members of the Senate Committee on Insurance, Licensing and Forestry, thank you for allowing us the opportunity to testify today in support of Senate Bill 753. My name is Andy Bagnall and I'm the President and CEO of HSHS Wisconsin. This includes six hospitals in eastern and western Wisconsin. Our organization provides high quality health care for thousands of patients in Green Bay, Sheboygan, Oconto Falls, Chippewa Falls and Eau Claire. Many of our patients travel quite a distance from rural areas to receive our advanced level of care. This means we work hard to make the most of their time with us to not increase their travel time and costs. Our HSHS hospitals are an important safety net for those in our communities who cannot afford life-saving medications like those that will be discussed today.

We want to inform the committee why this legislation is paramount to the patients we serve in our communities, including real life examples of when the insurance-required white bagging practice resulted in negative consequences to patient care. And by patient care, I quite literally mean patient lives.

I firmly believe white bagging and brown bagging instituted by insurance companies are moving health care delivery backwards for patients, greatly increasing the chance of error and driving patients away from the care teams they trust when they need us most.

There are many concerns about white and brown bagging, but today I will speak about what I consider the top three.

Patient Safety is number one – it's what we as a health care system are trusted to do every minute of every day. It's at the core of what we do. We are the first line of defense when someone feels sick or gets hurt, need surgery, experiences a heart attack or stroke. A hospital is where patients should feel comforted and safe in expert hands.

That was the case for Koreen Holmes, whom Koreen's Law is named. She expressed to you today how vested she was in her health care team at the cancer center within HSHS Sacred Heart Hospital in Eau Claire. Then in July of last year she was told she may have to switch care teams. Suddenly white bagging became as important to her as her fight with cancer. As if cancer wasn't enough.

Koreen is not *one* of a handful of patients who was affected by white bagging – there are many more Wisconsinites facing cancer, rheumatoid arthritis, multiple sclerosis, macular degeneration, blood disorders, Chrohn's Disease, endometriosis and other conditions that require medications that are on the white and brown bagging list. The safety of those medications and the consistency of patient care is in question if this continues.

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Since the white bagging policy began, nearly 50 patients at HSHS Wisconsin hospitals have been impacted; and obviously we are just one of many health systems in the state.

As you heard, Koreen was one of the fortunate ones who, with the support of her husband Nate, implored her insurance company to grant a 90-day extension – and got it, which was just enough time to complete her cancer treatments. But what if it comes back? Then she's on her own to pay for expensive medications or find another hospital willing to infuse white bagged medicines. And what about everyone else who is just starting treatment, or in the middle of treatment? I wouldn't say patient safety is guaranteed in Wisconsin if white and brown bagging continues.

Quality of care is my second topic.

For nearly 150 years the mission of HSHS - Hospital Sisters Health System has been to care for all people through high-quality Franciscan healthcare ministries. Individualized, superior care is the standard of all we strive to do. We set our goal at zero harm to our patients and that starts with high quality standards of care delivered by expertly skilled care teams.

If our clinical hospital staff cannot control the entire medication handling process from ordering to infusing, the quality of care we provide is compromised; not in terms of how we interact with our patients, or the extensive experience we offer, but rather the level of confidence we impart if we were to infuse medications we cannot guarantee the safety of – or that we have to reorder because the dosage has changed since the patient's last visit. Asking a patient to return another day because the medication we ordered isn't correct is *not* high quality of care.

And this is not a hypothetical situation.

Recently an HSHS patient with Ulcerative Colitis was overdue for an infusion. The patient was not aware of the white bagging insurance policy until calling the hospital to schedule the infusion. Because this patient had to then call the insurance company to request an exception authorization – which, by the way, was something the patient didn't even know how to ask for. Our hospital staff had to provide the correct words and phrases for this patient to use when making the request – the infusion couldn't be scheduled. The exception, if granted, would allow HSHS to buy and bill the drug instead of white bagging. By the time this exception was granted, the patient was a month overdue for treatment and was in such a worsened condition the patient didn't respond to the medication. Today this patient is on Humira and still not in remission.

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Most GI patients who have had treatment delays because of white bagging were one week or more late for infusion. Some decided to go on steroid tapers to get through the delay until their next infusion. Those steroids come with their own side effects and our hospitals do not use them unless it's crucial to control a flare up. Interestingly, the flare up is typically caused because infusion treatment is not received. Not one of those GI patients said they received prior notification that a policy change regarding medication coverage was happening; many said they felt blindsided and the situation caused them added stress.

Care Delivery is the final point I'll address today.

Most providers in the markets where HSHS operates hospitals do not – and will not – allow white bagging because of safety concerns.

Some insurance plans will not allow an exception to white bagging regardless of circumstance. This creates a situation in which patients are advised by their insurance company to seek infusion from a provider that is okay with white bagging, however more and more providers do not have capacity to accept patients who do not have established care with them.

If HSHS will not participate in white bagging, and other providers won't accept new patients for treatments – where do they go? How far do they drive? How do they get life-saving infusions?

To compound matters, often patients are well into their treatment regiment when a drug is placed on the white bagging list within the specialty pharmacies the insurance companies work with. Transitioning care isn't just an inconvenience – it is an entire disruption in their care. It forces patients to start over with a provider they do not know and a care team they aren't used to. This causes delays and duplication of services.

Hospitals also never know what medications are on the list from month to month. The policy allows insurers to add or remove medications at any time without prior notification to patients or health care entities. This puts our patients, providers and colleagues at a clear disadvantage and adds a great amount of unproductive time as they must call insurance to verify the requirement prior to each treatment.

Also, the white and brown bagging policy is not universal; each insurance company is allowed to maintain its own list of specialty medications.

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Care delivery is also a workforce challenge that impacts resources.

Our people are the greatest resource within our health care system, without them we cannot care for members of our communities. We have been stretched to the breaking point; even before the pandemic we were stressed with workforce challenges. The day-to-day impact of this has never been greater. It obviously takes financial resources to recruit, retain and reward our colleagues and when those financial resources are allocated elsewhere, or if the revenue cycle is negatively impacted, we need to shift assets to continue providing high-quality patient care.

When we purchase medications as a hospital, our colleagues have direct control over the purchase, storage, chain of custody and infusion to patients. We can also pivot quickly if a patient presents with complications since his or her last visit. This could mean mixing medications on-site, altering the dosage, or even changing the medication completely. Those options are not options if the drugs come from a specialty, insurance-mandated pharmacy via the mail. Each white bagged medication is earmarked for a specific patient and if that patient cannot receive the medication, it's wasted – physically and financially. However, if the medications are purchased directly by our hospitals, they are available to any patient who needs them- not just one specific patient.

What complicates this even further is that hospitals have agreed upon contracts with insurers already in place. When changes are made mid-cycle, as was the case when white bagging began, health care providers are put in a tenuous situation.

A final note on care delivery. HSHS often experiences situations in which a patient is advised by their employer that their plan doesn't have a white bagging policy, yet their insurance administrator applies it to their claim. This causes HSHS to repeatedly dedicate resources toward educating the insurance company's groups and members about *their own plan*.

Now imagine yourself as a patient being told *you* must contact your insurance company to request coverage of the drug you desperately need to fight cancer, eliminate excruciating pain or receive medications for a new diagnosis. In Koreen's case – she and her husband didn't even know what to ask for. Their own insurance company asked them, "what is white bagging?"

In conclusion, patient safety, quality of care and care delivery are compromised if white and brown bagging continues in Wisconsin.

HSHS Sacred Heart Hospital in Eau Claire does not white or brown bag. As a result, when patients come to our cancer center seeking care, we take extra time to explain white bagging to them so they can make an informed decision about their health care.

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This has resulted in 10 potential patients deciding to find care elsewhere after they learn their drugs may be on the white bagging list.

I hope you've heard not only the facts from my perspective as a hospital administrator, but also the passion with which I support the proposed Koreen's Law. The consequences of white bagging and brown bagging implemented unilaterally by insurance companies outside contract negotiations, are creating substantial care-fragmentation problems for our patients resulting in delayed care and potentially unsafe medications.

When our health system has an already agreed upon contract with an insurance company to dispense a medication to a patient, payment should not be denied when it is medically appropriate. HSHS Wisconsin asks for your support of Senate Bill 753. Your vote can ensure the white and brown bagging policy no long exists – and does not put patient's lives at risk. If one person – one family – experiences the ultimate negative consequence because of this policy, it is too many, especially when the necessary, safety-controlled medications are already sitting on the pharmacy shelf in our hospitals.

Let's be among one of the first states to ban white bagging and put patient care back in the hands of patients. *YOU* can take a stand to end white bagging which puts the safety of your constituents into question. Wisconsin does not need to be first in the nation to lose a patient because white bagging or brown bagging caused a delay in patient care.

Please support Koreen's Law. Thank you.

The Alliance
Self-Funding Smart

Testimony Opposing Senate Bill 753, Relating to Clinician-Administered Medications

Cheryl DeMars, President and CEO – The Alliance

Senate Committee on Insurance, Licensing and Forestry

January 20, 2022

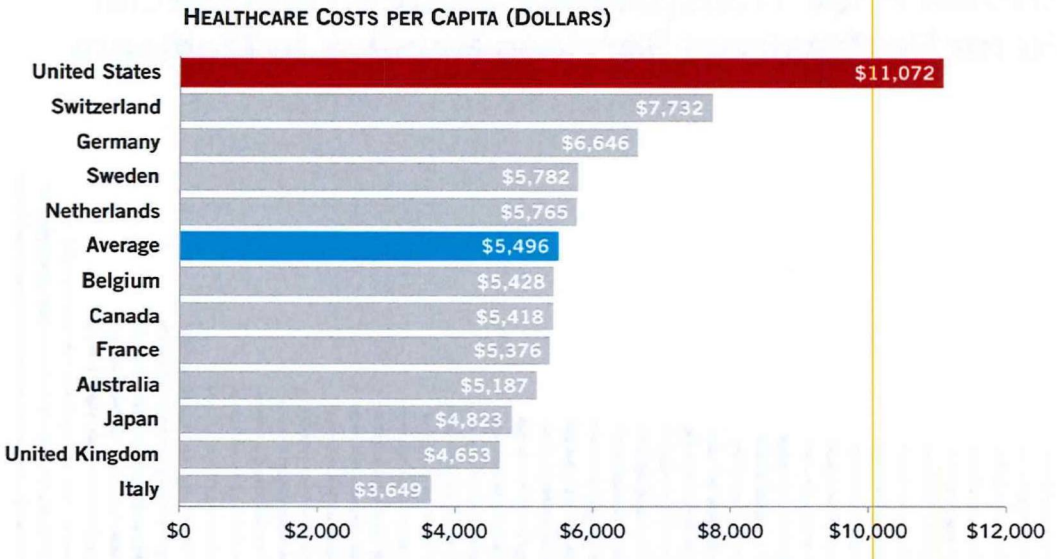
I am Cheryl DeMars, President and CEO of The Alliance. The Alliance was founded over 30 years ago by employers in WI as a not-for-profit health care purchasing cooperative with the goal of controlling health care costs while improving the quality of care. Today, there are over 300 employers from across the states of WI, IL and IA, who work together through The Alliance to manage the cost of the health benefits we provide to our 105,000 employees and family members.

On our behalf, The Alliance negotiates contracts directly with thousands of doctors and hospitals to support our self-funded health benefit plans. Self-funding means that an employer pays directly for the health care services used by their employees versus buying coverage through an insurance company. Self-funding creates extra motivation for employers to invest in employee health while controlling costs through innovations such as workplace clinics, employee wellbeing programs and strategic sourcing of costly goods and services.

The price we pay for health care services in our country is simply becoming unaffordable for us and our employees. The United States is an outlier among other industrialized countries, putting us at a competitive disadvantage in a global economy.

PETER G. PETERSON FOUNDATION

U.S. per capita healthcare spending is almost twice the average of other wealthy countries



SOURCE: Organisation for Economic Co-operation and Development, *OECD Health Statistics 2020*, July 2020.
NOTES: The five countries with the largest economies and those with both an above median GDP and GDP per capita, relative to all OECD countries, were included. Average does not include the U.S. Data are for 2019. Chart uses purchasing power parities to convert data into U.S. dollars.

PGPF.ORG

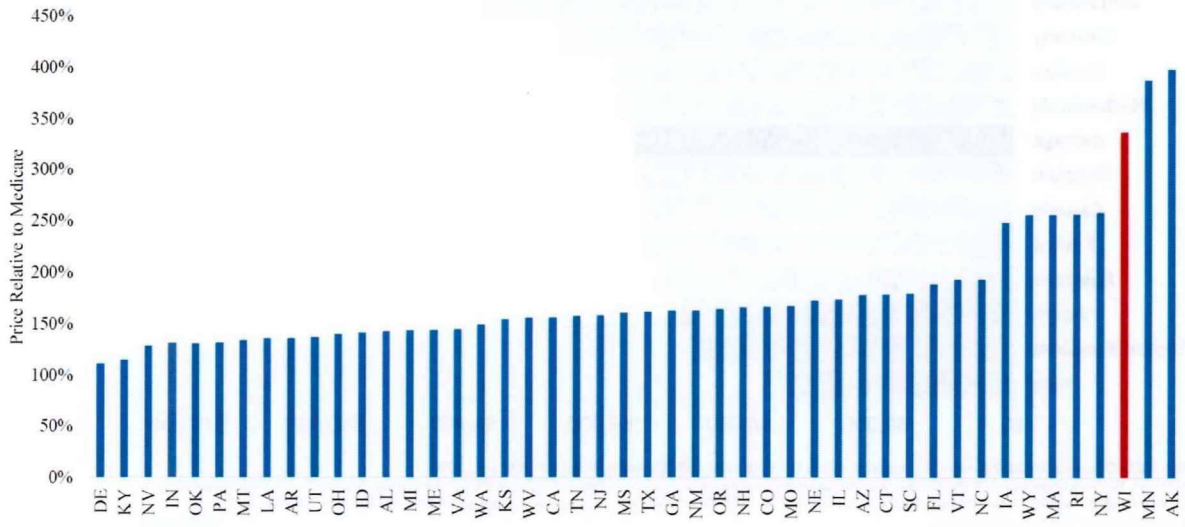
What's more, in Wisconsin, prices for the commercial market (non-Medicare and Medicaid) are abnormally high compared to other parts of the country. According to the most recent data from the RAND Corporation, we are tenth in the country in terms of hospital prices, and we pay the third highest physician prices.

RAND Hospital Price Transparency Study
Total Relative Price by State

Source: RAND 3.0 Hospital Price Transparency Study, September 2020
https://www.rand.org/pubs/research_reports/RR4394.html

page 5

RAND Hospital Price Transparency Study – Commercial Price Paid for Professional Services Relative to Medicare



Our Wisconsin companies and our employees are shouldering the burden of high health care prices – paying 291% of what Medicare pays for the same services from the same providers. The high prices we pay erode our ability to grow our businesses and improve wages and benefits for our employees. At the same time, medical bills are the largest single cause of consumer bankruptcy, even among consumers who have insurance.[1]

These charts illustrate Wisconsin's high prices for medical services, but don't fully depict what's happening with prescription drugs. Just 10 years ago, Milliman data[2] shows pharmacy costs were 15% of the annualized cost of providing health benefits to a family of four. In 2021, prescription drugs now make up 22% of the total cost – an increase of 114% over 10 years. Some of this increase is likely attributable to new, beneficial drugs coming to market – we celebrate these innovations. But we are unwilling to tolerate egregious price gouging by hospitals who add, on average 200 – 400% to their acquisition price.[3]

Wisconsin employers are simply not willing to accept the status quo of unchecked prescription drug price increases. We are taking proactive measures to control costs while ensuring that our employees and their families get the care they need. Buying prescription drugs through lower-priced alternative sources, or "white bagging" is one tactic that can help to control the cost of specialty medications that must be administered by a clinician. Alliance members who use this approach do so while taking steps to ensure safe, timely care for their employees.

The table below illustrates the impact of hospital mark-ups on one Wisconsin employer and the potential savings for this company and their employees.

Savings Potential Through White Bagging
January – June, 2020

Drug	Procedure Code	Claim Count	Traditional Provider Price, including mark-up	Alternatively Sourced (aka white bag) Price	Total Estimated Savings	% Savings
Aldurazyme	J1931	24	$192,313	$42,094	$150,219	78.1%
Botox	J0585	20	$24,774	$8,635	$16,139	65.1%
Euflexxa	J7323	3	$1,437	$580	$857	59.6%
Gel-One	J7326	2	$960	$532	$428	44.6%
Monovisc	J7327	1	$1,364	$936	$428	31.4%
Synvisc One	J7325	4	$5,420	$3,707	$1,713	31.6%
Zoledronic Acid	J3489	6	$2,987	$2,224	$763	25.5%

[1] Daniel Austin, Medical Debt As a Cause of Consumer Bankruptcy (Jan. 2014), *available at* https://repository.library.northeastern.edu.
[2] Milliman Research Report, 2021 Milliman Medical Index, May 2021.
[3] The Moran Company, Hospital Charges and Reimbursement for Drugs: 2019 Update Analysis of Markups Relative to Acquisition Cost;, July 2019.

Passing AB718/SB 753 will limit market competition, making important drugs even less affordable. This is not a step that Wisconsin lawmakers should take with more and more life changing and life-saving medications coming to the market. We need to find ways to help employers and their employees afford these medications. Instead, this bill will do just the opposite.

Please feel free to contact me directly if you have questions or need additional information.

Cheryl DeMars, President and CEO
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Testimony Opposing Senate Bill 753, Relating to Clinician-Administered Medications

Sara Hames, NBS Advisors, LLC

Senate Committee on Insurance, Licensing and Forestry

January 20, 2022

My name is Sara Hames with NBS Advisors, LLC. I've spent the last several decades working with employers to help them successfully manage the increasing cost of health care in this country and, especially, in Wisconsin. Thank you for taking the time to better understand the forces involved in this complicated health care ecosystem.

The cost of specialty medication is 50x more expensive than a non-specialty drug. 717 new specialty drugs were approved by the FDA from 2000 to 2021. These drugs can cost anywhere from hundreds of dollars to tens of thousands of dollars when purchased directly from manufacturers. Add the hospital's mark-up of 200 to 1000% results in outrageous payer price-gouging.

A review of one employer's data, found 16 claims for a fairly common drug that retailed for $600, marked up to $6,000 by a Wisconsin hospital. The employer paid $96,000 for these drugs when they could have paid $9,600 if sourced alternatively!

For many employers, specialty drugs now account for 50% or more of their entire pharmacy spend and the costs grow higher every day. U.S. prescription drug prices are 2.56x higher than those in other developed countries mostly due to mark-ups in the supply chain including hospitals. Imagine as an employer adding $439 per person per year to the cost of your product or service just to cover specialty drugs. And imagine as a consumer, one of the 50% who has less than $1,000 in a savings account, having to pay thousands of dollars for each treatment or skipping treatments entirely because they're unaffordable. That's the reality of health care in Wisconsin today. Robbing our employers and residents to pad the profits of hospitals by passing this bill is not only devastating to our economy, it's an assault on the free enterprise upon which our state and country are built!

Helping employers design strategies to mitigate these egregiously inflated costs and get employees the care they need is essential to providing affordable health care to them. And I'm proud to claim it as my expertise. My voice is the voice of many employers determined to change health care.

Safe 'white-bagging' is one of these strategies. The employers I work with have a rule built into their health plans: if the prescribed drug cannot be alternatively sourced and delivered on time, allow the hospital to source it. Patients come first, always! Employees are the foundation of any company. Safety on the job and in the benefits they offer is paramount. White-bagging or alternative sourcing is no exception.

Alternative sourcing isn't just about saving money for employers; it also lowers the cost of expensive medications for employees and family members and ensures that the health plan can continue covering these life-saving medications. For example: one of my clients reduced their prescription drug spend by 49% and was able to deliver free or low-cost medications to everyone who needed them. They will save another 6% of their spend this year on white-bagging alone. Another client is projected to save over $700,000 through alternative sourcing including white-bagging and members spend far less on

prescriptions than they did in the past. Employees and family members are generally thrilled and there have been no complaints regarding safety issues. Passing this legislation means increasing costs to both the plans and the members. So who gains by passing this bill? Clearly, the hospitals, some that have millions or even billions in unrestricted reserves.

Accepting the status quo of the terribly broken health care system in WI is not an option for many employers. Finding safe, cost-effective strategies to temper the sky-rocketing cost of health care in Wisconsin is not only a good free market business practice, it's an employer's fiduciary responsibility. How can state representatives even consider such an attack on the free enterprise initiatives of these forward-thinking companies and their employees struggling to afford their medical bills? Passing this bill will likely guarantee that employer and employee health care costs will increase even further, benefits will be cut, and life-saving drugs will no longer be covered by some health plans/employers. If that's a 'win' for the state, many employers will look elsewhere to invest and grow.

If you have any questions, please do not hesitate to reach out to me at 414.374.3805 or sara.hames13@outlook.com.

Sara Hames
Principal
NBS Advisors, LLC

CSRO
Coalition of State Rheumatology Organizations

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January 19, 2022

Senate Insurance, Licensing, and Forestry Committee
2 E Main Street
Madison, WI 53703

Re: Support for SB 753

The Coalition of State Rheumatology Organizations (CSRO) is a national organization composed of over 30 state and regional professional rheumatology societies, including our member organization in Wisconsin. CSRO was formed by physicians to ensure excellence and access to the highest quality care for patients with rheumatologic, autoimmune, and musculoskeletal disease. It is with this in mind that we write to you regarding SB 753.

As you consider SB 753, CSRO would like to share its support and the importance of ensuring that providers continue to be able to provide care for patients through the buy and bill acquisition model for provider administered prescription drugs.

Many rheumatology practices currently use the "buy and bill" method of acquisition for provider administered drugs. Under this model a practice will purchase, store, prepare, and administer certain provider administered drugs. The practice will then bill the payer for the cost of the drug and its administration once a patient receives treatment.

Payers have begun to require that providers use an alternate acquisition system called "white bagging" for provider administered drugs. White bagging is a policy in which insurance companies internally manage the purchase and delivery of provider administered specialty medications through a specialty pharmacy of the insurer's choice rather than allowing the provider, where the patient will receive treatment, to purchase and manage drug inventory for their patients. CSRO believes this new system is flawed for a number of reasons, and that Wisconsin policymakers should act to curtail its mandatory use by payers.

White Bagging Reduces Patient Safety and Increases Practice Liability

CSRO has serious concerns with product integrity for drugs prepared outside of rheumatologists' offices. Under the white bagging model practices do not have control over the handling, preparation, and storage conditions of the drug prior to its administration. Improper handling on the part of a specialty pharmacy can have serious consequences for patients, and white bagging removes practices' ability to prevent adverse events through internal oversight. Patients will face delays in treatment and unnecessary hardships, as compared to the practice sourcing products from its own inventory for in-office

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administration. **Indeed, in a national survey of rheumatologists, 69% of respondents indicated they experienced operational and safety issues associated with white bagging.**[1] While practices' responsibility for much of the pre-administration handling is removed under the white bagging model, their liability is not. Practices may still be held liable for adverse events that occur because of circumstances they no longer control under a white bagging model.

White Bagging Requirements Delay Care and Increase Drug Waste

White bagging would significantly increase instances of drug waste, which complicates the acquisition system's ability to achieve savings. Under the new policy, drugs will be assigned to a specific patient prior to administration by the specialty pharmacy, whereas under buy and bill drugs do not have to be assigned until the time of administration. Providers cannot administer a drug assigned to one patient to a different patient, whereas they may do so with drugs acquired through "buy and bill."

For example, if a dosing change is required or the therapy is discontinued or interrupted for any reason, the drug provided by the specialty pharmacy would end up as waste. It is not uncommon for pre-administration evaluation to necessitate dosing changes, which the white bagging model offers no ability to resolve without drug waste or inability of the patient to get the needed dose of medication. This would certainly result in unnecessary drug waste and increased expenditures for the patient in terms of money and health.

Additionally, the present "buy and bill" system offers providers flexibility that would prevent patients from suffering major inconveniences should delays or other mistakes occur on the part of the specialty pharmacy or their delivery system. Delays can result from a variety of factors, including failed delivery, incorrect medications being delivered, medications shipped to the wrong address, prior authorization issues, and out of stock medications. Not only would the drug be wasted, but the patient, practice, and payer's time is also wasted with potential harm to the patient due to their inability to get the needed medication. **68% of respondents to CSRO's national survey indicated that medication delivery was delayed when white bagged, which caused patient appointments to be canceled and increased chances of drug waste.**[2]

These logistical hurdles are not only borne by patients, but also physician practices. Due to the aforementioned issues, the requirement to white bag drugs will massively increase the complexity of inventory management, which will add to already untenable administrative burdens borne by physician practices. Practices will now have to keep track of individual drugs for individual patients, which drugs can be used if treatment is delayed, how long of a delay is acceptable for reuse if treatment is delayed among other issues. As

[1] CSRO national survey of rheumatology practices, data available upon request.
[2] CSRO national survey of rheumatology practices, data available upon request.

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a result, inventory will have to be more granular, which presents and overhead and inventory nightmare.

White Bagging Requirements Reduce Affordability for Patients

Due to the expensive nature of many specialty medications, patients are often responsible for large cost-sharing amounts out of their own pockets. Many patients are unable to afford these amounts all at once, and providers work with patients to spread these payments over time to help ensure they are able to afford and receive treatment. However, under a white bagging model, there is the possibility that patients may need to meet their cost-sharing obligations in their entirety before the specialty pharmacy will ship the medication. An inability to meet these costs up front can interrupt critical treatment that is preventing the progression of disease.

For these reasons, CSRO requests your support for SB 753.

We appreciate your consideration of our comments.

Respectfully,

Madelaine Feldman, MD, FACR
President, CSRO

Testimony Opposing Senate Bill 753,

Relating to Clinician-Administered Medications

Megan Zimmerman, Vice President-Marsh McLennan Agency

Senate Committee on Insurance, Licensing and Forestry January 20, 2022

My name is Megan Zimmerman, Vice President with Marsh McLennan Agency a subsidiary of Marsh McLennan companies, world's leader in risk strategy and human capital consulting. I work with employers in various industries on their health plan and benefits offerings. My area of focus is strategizing on the health plan to find innovative solutions to deliver accessible, quality care healthcare while mitigating cost. Thank you for the opportunity to discuss the current, employer sponsored healthcare market in Wisconsin.

From my experience, the heart and success of great companies are the employees and the culture built within these organizations. In today's competitive labor market, offering a robust and cost competitive benefits package is a key component to attracting and retaining talent. [1]For job seekers, 60% of candidate's report benefits and perks are a major factor in considering whether to accept a job offer. Better health insurance coverage is the number one benefit valued by job seekers.

Next to salary, health insurance is the most expensive benefit employers provide. The Health and Benefits package is typically the second or third largest operating expense for employers. [2]In Wisconsin, Total Health Plan Costs per Employee per Year in 2021 were nearly $15,000. Health care in Wisconsin is more expensive than our neighbors in Iowa, Michigan, and Illinois. Currently, pharmacy cost trend in Wisconsin outpaces medical cost trend. Specialty medications now accounts for 50% or more of the entire pharmacy spend.

Employers, employees and their families in Wisconsin are paying more for pharmacy and health care costs than almost all our neighboring states. To mitigate cost and get employees access to the affordable health care they need, procurement programs such as safe "white bagging" are essential to protect employers and employees financial well-being. Banning, effective "white bagging" programs with proper patient safe guards will lead to cost increases. A growing portion of the cost increases are likely to be subsidized by the employees.

Employees and their families cannot continue to afford the increasing burden of rising healthcare costs. [3]Over 60% of bankruptcy filings are tied to medical bills with insurance coverage. One out of every six Americans has an unpaid medical bill on their credit report.

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[1] The Most Desirable Employee Benefits (hbr.org)

[2] Mercer's National Survey of Employer-Sponsored Health Plans

[3] 'I live on the street now': how Americans fall into medical bankruptcy | US healthcare | The Guardian

Pharmacy Society of Wisconsin

Testimony before the Senate Committee on Insurance, Licensing and Forestry
2021 Senate Bill 753 – "Koreen's Law"
January 20, 2022

Melissa L. Theesfeld, PharmD
Board Chair, Pharmacy Society of Wisconsin
Assistant Dean for Clinical Affairs, Concordia University School of Pharmacy

Good morning, Chairperson Felzkowski and members of the committee. Thank you for the opportunity to testify today in support of Senate Bill 753. My name is Melissa Theesfeld, and I am here today on behalf of the Pharmacy Society of Wisconsin. I am a pharmacist and the Board Chair for PSW, an organization representing pharmacists from practice settings across Wisconsin. Our membership includes pharmacists practicing in community pharmacies, clinic settings, and hospitals, as well as in managed care organizations and health plans. Pharmacists provide important medication management information and decisions in all of these settings. My colleagues in managed care use evidence-based rationale to structure medication benefits for populations of patients. Population-based decisions are not, however, always right for individual patients. Patients, pharmacists, and physicians need to have the tools to provide the best care for individuals and not be hamstrung by policy decisions for business reasons.

When implemented for broad populations, white bagging compromises the safety of medications and negatively impacts individual patients, which is why PSW supports Senate Bill 753. PSW's mission includes improving the quality of medication use for patients, and our strategic plan emphasizes advocating for patient access to necessary health care and medication resources. PSW strives to put patients first in all of our work. Senate Bill 753 gives individual patients choice in their healthcare decision-making and maintains a safe supply chain of medications.

Pharmacists and pharmacies are critical components of an integrated and patient-centered health care team. But mandated white bagging introduces risk, confusion, and delays. Patients no longer choose who is part of their care team. This bill would allow patients to get their medications from in-network pharmacies and pharmacists that they are already familiar and comfortable with. They can maintain the important relationships that contribute to their safe and effective care.

In addition to being a pharmacist, I am also the mother of a 10-year-old daughter who requires an injectable medication each month. Our family first began this health care journey with our daughter Kate just about a year ago when she started breaking out in hives multiple times each day. After 3 months of over-the-counter and prescription medications, nothing was helping. Our pediatrician and

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allergy specialist worked collaboratively to determine that the next step in Kate's treatment would be a monthly injection. I soon learned that our insurer required that this medication be purchased from a specialty pharmacy and shipped to the clinic. We didn't have a choice in where the medication would come from. All of a sudden, I found my family right in the middle of a white-bagging scenario.

Navigating insurance coverage issues, payment, and shipping took weeks. Kate's first injection had to be delayed because our payment wasn't processed appropriately, then the medication didn't ship on the day it was scheduled, and it was addressed to the wrong person at the clinic. Nurses and physicians called multiple times to try to rectify the situation. On top of their phone calls, I was calling too. And this whole time, Kate was miserable. The first injection was helpful and Kate had good results, so we were hopeful that things would run smoothly in the future. But then, there was confusion with her second injection. The price was now different, and all of the phone calls to the specialty pharmacy had to be repeated to verify shipping, payment, and the scheduled administration date.

I am a pharmacist with years of experience working in a large health system, and navigating getting this medication for my daughter is hard work. Every month is different and requires hours of my time and the time of her health care team. White bagging practices have been forced onto my family and have disrupted the care that my daughter receives. But our story is not uncommon. This happens to many patients who face frustrating and confusing choices about their medications in the midst of already challenging situations.

On behalf of the Pharmacy Society of Wisconsin, I want to reiterate our support of Senate Bill 753. This important bill aligns with PSW's goal of keeping patients' best interests at the forefront of our work and decision-making. Thank you for your time.

Pharmacy Society of Wisconsin

The Honorable Mary Felzkowski
Chair, Senate Committee on Insurance, Licensing and Forestry
Room 415 South, Wisconsin State Capitol

January 20, 2022

Re: Pharmacy Society of Wisconsin Support for Koreen's Law – Senate Bill 753

Chairwoman Felzkowski and members of the Senate Committee on Insurance, Licensing and Forestry, thank you for this opportunity to speak about a practice that is negatively impacting the citizens of Wisconsin, including the patients I serve each and every day. My name is Nick Ladell. I am a Director of Pharmacy at the Aurora West Allis Medical Center, a hospital in West Allis, Wisconsin. In addition, I serve on the Pharmacy Society of Wisconsin Board of Directors. Over the years in my role, I have personally seen a growing number of patients negatively impacted by the insurance practices we are discussing today. Unfortunately, these practices are not just impacting patients at my facility – it is impacting patients seen in clinics and hospitals across the entire state of Wisconsin. These practices have the potential to impact any patient that needs a medication administered by clinicians (children, elderly, cancer fighters, those inflicted with GI and neurologic disorders, and many many more). Due to the broad negative impact that I have personally witnessed way too many times, I chose to come and speak today.

As a member of the PSW Board of Directors, I have heard many stories from pharmacy leaders across the state. All describe the same issues. Issues I am challenged with each and every day. The insurance practices described today are fragmenting care, causing delays, and putting patients at risk – but most of all, causing emotional and physical harm to patients. Real pain. Real strife. If it wasn't for the tears, the emotional letters from patients, relapses, and the stories of hardship, I am not sure I would be here today. Understanding this policy can help the citizens of Wisconsin, I am glad I am here to tell their story.

To help explain the problem, imagine being diagnosed with Crohn's disease, a fairly common debilitating GI disorder. Your provider wants to start therapy right away so you can get the debilitating flare up under control and return to a normal lifestyle, return to work, and be in control of your health. You learn that your insurance requires white or brown bagging. So, after many phone calls, confusion, and coordination, you receive the medication delivered to your home, but you can't find anyone to infuse it – why? Because very few care teams will infuse a "brown bagged" medication that could be unsafe due to questionable integrity from unreliable storage and handling. Toss that vial away; let's start over.

So you start over. After many phone calls, confusion, and coordination, you have it worked out with the insurance company to send medication to a local outpatient infusion clinic. After

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multiple meetings and phone calls, the infusion clinic pharmacy and care team work with your GI provider to coordinate your care. The care team works with a pharmacy 1,000 miles away required by your insurance. The medication is sent. Success!... Wrong, the pharmacy sends it via a courier that doesn't typically deliver to the infusion clinic pharmacy, nor handle medications regularly. The medication is lost.

So you start over. After many phone calls, confusion, and coordination, you have the medication shipped again. This time it arrives! Success!... Wrong again, the dose was incorrect and, due to fragmented care, this error isn't realized until received by the infusion clinic pharmacist with specialized training. You have too little drug.

So you start over, this time, all goes well. The correct dose of the medication is received and administered. You are exhausted, you have rescheduled your appointment multiple times, made an unknown amount of phone calls, and your GI disorder has worsened due to the delays.

In 4 weeks, you are anxious about repeating the whole process for your next dose. More phone calls, more breakdowns, more missed days of work, more sleepless nights, more chances that your GI disorder will relapse by not receiving your treatment on schedule, and more frustration that you are not in control.

This isn't a hyperbolic scenario. This is a real story. This isn't uncommon or something that only happened one time. Theseare real, preventable events that have been inflicted on dozens of patients at just one hospital in Wisconsin. It is time to put the health of Wisconsin citizens first and prohibit the mandate practices of white and brown bagging. I want to end by thanking you. Thank you for your public service and professionalism - but most of all, thank you for listening. Please support Senate Bill 753 so that we can provide the best patient care in Wisconsin.

Sincerely,
Nick Ladell, PharmD, MBA, BCPS
Director of Pharmacy
Aurora West Allis Medical Center
Board of Director
Pharmacy Society of Wisconsin

Cc: Members; Senate Committee on Insurance, Licensing and Forestry

Testimony of Jordan Dow, Director of Pharmacy Services,
Mayo Clinic Health System, Northwest Wisconsin
Wisconsin State Senate Committee on Insurance, Licensing and Forestry
Thursday, January 20, 2022, 10:00 AM, 411 South State Capitol

Madam Chair and fellow Senators,

My name is Jordan Dow, I am the Director of Pharmacy Services for Mayo Clinic Health System in Northwest Wisconsin. Thank you for the opportunity to address this important topic today. At all of our Mayo Clinic sites, which includes more than 15 rural communities such as Bloomer, Barron, Sparta, Glenwood City as well as Menomonie, Eau Claire and La Crosse, our mission is "The needs of the patient come first.". First and foremost, we view white bagging as an unsafe practice for our patients. Secondly, it is inefficient and costly for health care providers and ultimately to our health care system.

We view white bagging as **unsafe** for our patients due to how the product is delivered.

Product delivery

We contract with our suppliers and distributors to procure our medications in a consistent way, that ensures complete product tracking/traceability, so we know where that product came from, and temperature control. These are critical to us in order to guarantee product integrity and meet the transaction tracking information required by the FDA Drug Supply Chain Security Act (DSCSA) of 2013. Through our contracted means, our medicines arrive daily at the same time, at the same delivery point, and are efficiently transitioned into our inventory and temperature tracking systems. This approach also enables us to manage our inventory efficiently and manage our costs effectively. Notably, many medicines that are targeted for white bagging are temperature fragile medicines.

White bagging shatters this product delivery process

Under a white bagging scenario, payers force our clinic staff and patients to spend time coordinating approvals, payment and delivery, before the product is shipped. This causes delays in therapy for the patient. Once the product is shipped, it often arrives directly at the one of our 40+ clinics in NWWI. This is problematic for temperature tracking and ensuring the product integrity… it could easily sit on a receiving desk for hours and end up out of range and the integrity could be comprised. In this scenario, the product must be wasted (throwing away expensive medicine) and the process must be reinitiated (a time waste for all involved)… and causing a delay in treatment for the patient.

Also, the product does not arrive with the 3 T's that are required by the FDA under DSCSA for any change in product ownership: The transaction history, the transaction information and the transaction statement.

This creates uncertainty is our quality assurance for our patients. Similarly, we view white bagging as **inefficient** for our staff and our patients.

Typical scenario

A patient receives a new diagnosis, we can begin treatment as soon as the patient and care team agree on a treatment plan – even the same day as diagnosis. We can do this because we have the product in our refrigerator in our hospital pharmacy, ready for sterile and hazardous compounding or mixing in our clean rooms, and providing it to the nurse to administer to the patient.

White bagging

The patient needs to work with our care team, the payer, and the specialty pharmacy to gain approval, pay for the product, coordinate delivery and schedule their visit. This regularly takes more than 4 weeks. This is not just a one-time event either. A similar process may need to occur when doses are changed or payer changes are put into effect.

Also, our patients are people like all of us, and their conditions change, so they may need a change in their treatment.

They may need a higher dose of the same treatment, which results in us needing to delay and reschedule therapy while we procure more of their needed medication. This is a shame since we have the same medications sitting in our refrigerator but cannot use it for the individual due to the payer mandate.

In other cases, the patient's condition may change, and we need a different medicine. This can result in the previously white bagged product, that the patient has already paid for, being discarded because it is no longer a relevant therapy choice for them and it is not allowed be used for any other patient... again, this is a shame because this does not occur with our regular process since patients are not billed until after receiving treatment.

Ultimately white bagging is unsafe, inefficient and a disservice to our patients... which is why I am here asking for your support of this legislation to prohibit this practice.

Thank you.

AHI
ALLIANCE OF
HEALTH INSURERS

To: Chairperson Mary Felzkowski
Members, Senate Committee on Insurance, Licensing, and Forestry
From: R.J. Pirlot, Executive Director
Re: Opposition to SB 753, prohibiting certain practices relating to insurance coverage of clinician-administered drugs.

The Alliance of Health Insurers (AHI) is a nonprofit state trade advocacy organization created to promote essential and effective health insurance industry regulations that serve to foster innovation, eliminate waste, and protect Wisconsin health care consumers. We oppose Senate Bill 753 and appreciate the opportunity to share these concerns with the Senate Committee on Insurance, Licensing, and Forestry.

This legislation would ban, under the state's insurance and unfair marketing and trade practices law, important cost-savings practices health plans and pharmacy benefit managers (PBMs) utilize to provide drugs that must be administered by a clinician.

These specialty medications which are administered by clinicians, via injections and infusions, are used to treat a variety of conditions, from arthritis to chronic migraines to some cancer treatments. The cost of these treatments can be in the tens of thousands, and sometimes hundreds of thousands, of dollars range.

In recent years, health plans have seen a significant markup of these clinically administered drugs by hospitals and providers. AHI members have reported to us that a 300 percent to 500 percent markup on the average wholesale price (AWP) is not unusual. As health plans, our members are committed to ensuring plan participants and beneficiaries get the drugs they need in a timely, cost-effective manner. Through partnerships with specialty pharmacies, insurers can deliver these specialty medications right to the clinic or hospital where the drugs will be administered, and the cost savings thanks to this delivery model benefit the patients and their employers, both who ultimately pay for insurance coverage.

SB 753 would undermine the ability of our plans to use these cost-saving measures, ultimately driving up the cost of care for the lives our members cover.

Please consider the following:

If a provider charges an insurance company 500 percent AWP for a specialty drug which the plan can get for much less, SB 753 would leave the plan with no option but to pay the inflated rate, even if the plan could provide the drug for a near-AWP cost, which our members report they often can do.

In other words, SB 753 would allow a provider to charge whatever they want for a clinically administered drug because the bill would not give the health plan any ability to require the drug be provided in a more cost effective manner, provided patient safety and timeliness of administering the drug are not compromised. In short, the bill would allow a provider to obtain a

specialty drug and then charge a plan a significantly higher cost than what the plan could achieve.

This bill also would allow an enrollee, policyholder, or insured to obtain a clinician-administered drug from *any* provider or pharmacy of choice, undermining our plans' ability to negotiate with providers and pharmacies for lower prices. The purpose of our plans' networks is to help control the quality and cost of health care. SB 753 would be a significant step away from the long-standing principle that networks are an important tool to help provide affordable health insurance.

Historically, AHI member companies have found themselves opposing a legislative mandate or defending a cost-savings practice like prior authorization or step therapy. SB 753 is something completely different. The bill does *not* change coverage of specialty drugs. Patients need these important medications to live a productive life and our plans properly cover them. We do not object to paying for the medications our members need.

We object to SB 753 because it stacks the deck in favor of hospitals, providers, and pharmacies by allowing them to charge whatever they want for clinician-administered drugs, with our plans and, ultimately, their policyholders, paying the bill. This legislation eliminates nearly every cost-saving tool an insurer could utilize to bargain for better prices for these specialty medications, again, with the resultant higher costs being passed along to policyholders.

Thank you for this opportunity to submit testimony today and we respectfully ask you oppose Senate Bill 754 for the reasons shared here.

Senate Bill 753
Senate Committee on Insurance, Licensing & Forestry
AHIP TESTIMONY

Good morning, my name is Sergio Santiviago and I am Vice President, Drug Policy, for AHIP. We are a national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, businesses, communities, and the nation. Americans deserve access to comprehensive, quality, affordable coverage. AHIP is committed to advancing policy solutions in support of these goals.

As an advocacy organization committed to market-based solutions that make access to high-quality healthcare affordable, I thank you for this opportunity to speak with you today on behalf of our members to share our serious concerns with, and opposition to, Senate Bill 753.

We believe everyone should be able to get their prescription drugs at a cost they can afford. And we all need to work together to lower out-of-control drug prices for patients. That means advocating with Big Pharma for lower prices, as well as ensuring that patients are prescribed prescription drugs and therapies that are right for them. Health insurance providers stand shoulder-to-shoulder with patients, fighting for both access and affordability.

The problem has long been—and still is—the price of drugs. There are many innovative strategies being used to lower drug costs for patients, and so-called "white and brown bag" dispensing through specialty pharmacies are among them.

But why have so many payers—the self-insured, publicly-funded, and other insurance plans—turned to this approach, and what are the circumstances that dispensing via specialty pharmacy is intended to address?

First, we must briefly describe specialty and clinician-administered drugs. These drugs generally are high-priced medications that treat complex, chronic, or rare conditions (e.g., cancer, multiple sclerosis, rheumatoid arthritis). Specialty drugs can also have special handling and/or administration requirements as this also includes most biologic drugs. Both the number and price of specialty drugs have rapidly increased in recent years,[1] and specialty drugs are a leading contributor to drug spending growth.[2] The price of a specialty drug can range from thousands to tens of thousands of dollars per regimen.

Notably, the "specialty drug" share of net spending across institutional and retail settings has grown from 27% in 2010 to 53% in 2020[3] according to recent study from the drug data firm IQVIA. Further, this study notes "[g]rowth will be driven by adoption of newly launched innovative products, which are expected to occur at higher levels than in past years with an average of 50-55 new medicines launching per year over the next five years, including those in oncology or with specialty or orphan status."[4] To put this in dollar terms, another study found "[a]verage annual gross spending and average total net retail spending on retail specialty drugs more than doubled from $61.1 billion in 2010-11 to $157.3 billion in 2016-17, respectively, and $49.6 billion in 2010-11 to $112.6 billion in 2016-17, respectively.[5]"

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[1] The Growing Cost of Specialty Pharmacy-Is it Sustainable? American Journal of Managed Care. February 18, 2013. Available at: https://www.ajmc.com/view/the-growing-cost-of-specialty-pharmacyis-it-sustainable.

[2] Projections of US Prescription Drug Spending and Key Policy Implications. JAMA Network. January 29, 2021. Available at: https://jamanetwork.com/journals/jama-health-forum/fullarticle/2776040.

[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] Id.

[5] https://www.uspharmacist.com/article/net-spending-on-specialty-pharmaceuticals-surging

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. But where do clinicians get these drugs to administer to their patients?

Next, it is necessary to explain how and from where clinicians can obtain these drugs for administration. Depending on the drug, they may be purchased by the clinician (or hospital) directly from the wholesaler, manufacturer via shipping, or from specialty pharmacies—with whom many manufacturers enter into limited distribution and/or dispensing arrangements to ensure the safe storage and handling of these expensive and delicate products. Specialty pharmacies are different from traditional "brick and mortar" pharmacies because they focus on dispensing drugs that retail pharmacies are not equipped to dispense.

Moreover, specialty pharmacies typically ship their products directly to clinicians just like a manufacturer or wholesaler would, but also—when safe and appropriate—to patients. Specialty pharmacies must also abide by all state and federal legal and regulatory requirements, including chain of custody (pedigree) tracking in addition to meeting extra safety requirements for specialty drugs imposed by the Food and Drug Administration (FDA) and drug manufacturers. 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.**

Which brings us to the focus of this proposed legislation and the practice more and more payers—including both public and private employers—are using to provide patients access to these costly medications. "White bagging," describes the practice whereby a specialty pharmacy ships a patient's prescription directly to the provider, such as hospital, clinic, or physician's office where it is held until the patient arrives for administration of the medication. Typically, under this process the hospital, clinic or physician does not purchase the drug and bill the patient's insurance (aka "buy and bill"), because the drug is provided to them by the specialty pharmacy. Instead, the insurer pays the provider the negotiated fee for the service of administering the medication in the appropriate setting and the specialty pharmacy for the cost of the drug. So-called "brown" bagging involves the specialty pharmacy shipping the drug directly to the patient, who then brings the medication to the physician for administration.

It is important to underscore that health insurance providers view patient safety as paramount and want patients to take these critical drugs at the time they are needed. And, when health insurance providers implement specialty drug administration policies, they **always** have exception processes in place to address circumstances of quality, safety, medical necessity, and/or care interruption.

> **Let's be clear: in every case, drugs must be safely dispensed. Health insurance providers only select medications for "white or brown bagging" when they are confident the drugs can be safely dispensed this way, and only when the patient is an appropriate candidate for such forms of dispensing.**

Specialty pharmacies are helping employers and other health plan sponsors safely address the growing costs of these particularly expensive drugs—which are then subject to even further, significant, markups above hospitals' and clinicians' acquisition costs. These markups are well-documented, including in several studies released this year:

- JAMA Internal Medicine (2021): The median negotiated prices for the 10 drugs studied ranged from **169% to 344% of the Medicare payment limit**.[6] The largest variation in markup came from Remicade, a IV drug that treats a range of autoimmune conditions – the median rate paid by commercial insurers at Mayo Clinic's hospital in Phoenix was more than 800% of the Medicare rate.

- Bernstein (2021): This analysis found that some hospitals mark up prices on more than two dozen medicines by **an average of 250%**.[7] For example, hospitals charged more than **5 times the purchase price** for Epogen, which is used to treat anemia caused by chronic kidney disease for patients on dialysis, and **4.6 times the price** for Remicade, a rheumatoid arthritis medication. According to the analysis, administering treatments to commercially insured patients is **20 times more profitable** than administering the same drugs to Medicare patients. The analysis also showed hospitals have been slow to begin using biosimilars, which are nearly identical to brand-name biologic treatments and produce the same health outcome, but at a much lower cost.

- Health Affairs (2021): This study examined the 2019 prices paid for by Blue Cross Blue Shield for certain drugs administered in hospital clinics versus provider offices.[8] The study found the prices paid for hospital outpatient departments were **double** those paid in physician offices for biologics, chemotherapies, and other infused cancer drugs (99-104% higher) and for infused hormonal therapies (68% higher). Blue Cross Blue Shield would have saved **$1.28 billion, or 26% of what they actually paid**, if the insurer had all patients receive their infusions in a provider's office instead of hospital clinics.

- AllianceBernstein (2019): Depending on the drug and type of hospital, markups ranged on average **3-7 times more** than Medicare's average sale price.[9]

- The Moran Company (2018): Most hospitals charge patients and insurers **more than double their acquisition cost** for medicine.[10] The majority of hospitals markup medicines between **200-400% on average**.

It is worth noting these markups on the price of the drug are **in addition to** the amounts hospitals separately bill insurers for the professional services required to administer the drugs.

> **Ultimately, patients, families, and employers all bear these unreasonable costs through higher health insurance premiums. It is imperative that health insurance providers help encourage the administration of these drugs in lower cost, more convenient settings when it is safe and clinically appropriate to do so.**

Unfortunately, SB 753 serves only to prevent use of such tools that safely encourage lower cost, high quality care that, in turn, allows health plan sponsors to stretch their health care dollars to provide more comprehensive coverage to their enrollees. Patients and payers are taking advantage of the introduction of competition into this care setting, driven by innovations in logistics and care services pioneered by specialty pharmacies that provide opportunities to drive out waste in this drug dispensing channel without sacrificing quality of care or access to these critically important medications.

In short, this legislation cuts off at the knees any meaningful, scalable effort to control one of the most significant and fast-growing portions of patients' and employers' health care dollar. These "just in time" processes for

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[6] https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2785833
[7] https://www.statnews.com/pharmalot/2021/01/20/hospitals-biosimilars-drug-prices/
[8] https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00211
[9] https://www.axios.com/hospital-charges-outpatient-drug-prices-markups-b0931c02-a254-4876-825f-4b53b38614a3.html
[10] http://www.themorancompany.com/wp-content/uploads/2018/09/Hospital-Charges-Reimbursement-for-Medicines-August-2018.pdf

delivering and/or dispensing specialty meds are, again, no different from the same ones used to deliver these drugs directly to the providers who would dispense them now, and if this legislation is passed. Moreover, administration of these drugs is provided in the same way regardless of setting—whether in the hospital, physician's office, independent infusion center or, where appropriate, certain retail pharmacy settings.

While we oppose SB 753 at the conceptual level, our concerns can be grouped by the following themes and this legislation's negative impacts on each: drug and service costs; patient access; patient safety and quality of care; medical necessity; market competition; fraud, waste and abuse; and freedom of contract.

Drug and Service Costs:
When it is safe and medically appropriate to do so, patients benefit from drugs being administered in the least restrictive and lowest-cost setting. Nearly every prohibition included in SB 753 will beget significant cost increases without demonstrating any clinical benefit for patients. Barring use of these tools will harm both for individual patients and the commercially insured population at large from receiving the right care at the right time, in the right setting, and at the likely lowest cost.

Provisions: 628.34(5m)(b)(1), 628.34(5m)(b)(2), 628.34(5m)(b)(6)
These provisions effectively ban prior authorization and other utilization management practices for clinician-administered drugs. These practices are put in place to support the delivery of high-value, cost-effective, and evidence-based medicine. Utilization management tools also save consumers and employers money by helping prevent costly and/or inappropriate care while encouraging the delivery of appropriate care in safe, lower-cost settings. Health insurance providers apply utilization management practices across a variety of health care products and services – clinician-administered drugs should be no different.

Provisions: 628.34(5m)(b)(3), 628.34(5m)(b)(4), 628.34(5m)(b)(5), 628.34(5m)(b)(9)
These provisions place inappropriate restrictions on health plan benefit design and would require health plans to treat clinician-administered drugs differently from any other health care product or service. These provisions also prevent health insurance providers from offering patients incentives (i.e., lower cost-sharing) to use lower cost providers.

For example, health plans may create tiered networks, which sort providers based on their cost and quality relative to other similar providers and offer patients lower cost-sharing when they seek services from a high-quality, low-cost provider. In addition, health benefit plans typically include different copays or coinsurance for different sites of care, which directly reflect the underlying cost of the service (e.g., a service delivered in an office visit has lower cost-sharing dollar amount than if the service is delivered in a hospital setting). Put differently, benefits are designed so that if patients obtain high-quality care from a lower-cost facility, they directly share in the financial savings via lower cost-sharing.

Under SB 753, these benefit designs would be prohibited for clinician-administered drugs, and therefore increase out-of-pocket costs and premiums overall for patients

Patient Access:
Administering drugs in non-hospital settings, when it is safe and medically appropriate to do so, improves patient access to vital medications by improving convenience, which ultimately contributes to better medication adherence. The health care industry is continuously innovating to safely deliver care in less intensive settings, as most recently evidenced by the rise of telehealth and hospital at home models.

Provisions: 628.34(5m)(b)(1), 628.34(5m)(b)(2), 628.34(5m)(b)(3), 628.34(5m)(b)(4), 628.34(5m)(b)(5), 628.34(5m)(b)(6), 628.34(5m)(b)(9)
Continuous innovation in medicine means that safety is not a static benchmark – and locking a fixed view of "safe" drug administration in state law, as SB 753 does, threatens to stall growth and adoption of care delivery methods that are easier, less disruptive, more flexible, and more convenient for patients to access. Further, if SB 753's

prohibitions on health insurance provider strategies to encourage use of less expensive care settings without sacrificing quality become law, patients are less likely to be made aware of options to receive care at a site like their home or an infusion center. Reduced use of these alternative sites also potentially threatens their viability and therefore ability to remain a competitive option for patients. Because affordability is a key component of improving access to health care, the cost concerns we identified in the previous section also impact patient access.

Provision: 628.34(5m)(a)(1)(b)
The broad construction of the definition of "clinician-administered drug" includes some drugs that can be administered by ancillary health care professionals in the home setting or an infusion center under the indirect supervision of a physician. Taking this definition together with the many prohibitions included in SB 753, some patients may actually lose access to a drug administration method they currently use due to cost or proximity concerns.

Patient Safety & Quality of Care:
Provisions: 628.34(5m)(b)(1), 628.34(5m)(b)(2)
These provisions effectively ban prior authorization and other utilization management practices for clinician-administered drugs. Utilization management tools are designed to support the delivery of clinically appropriate care and evidence-based medicine. If use of these tools is prohibited, health insurance providers will have no ability to intervene on a patient's behalf if, for example, a drug is contraindicated, inappropriate for the patient's diagnosis, prescribed for an inappropriate off-label use, or has other safety concerns.

Despite provider claims to the contrary, these policies are developed by independent committees comprised of clinical experts from the medical, academic, and pharmacy arenas, and reflect evidence-based reviews on best practices across a variety of health care products and services. Further, plans have procedures in place that allow providers to request an exception from such policies if the patient's medical circumstances and evidence adequately support it.

Provisions: 628.34(5m)(b)(3), 628.34(5m)(b)(4), 628.34(5m)(b)(5)
As described previously, health insurance plan designs are essential for steering members to high-value, high-quality service providers and locations. In the case of tiered networks, health plans often purposefully establish lower cost-sharing for providers who are of higher quality than their peers. State regulation of health insurance providers should foster these "value-based" arrangements rather than restrict it as SB 753 does.

Medical Necessity:
SB 753 goes far beyond prohibiting the practice of white bagging and reaches deep into many of health insurance providers' core practices. Specifically, this bill overreaches by eliminating the long-established ability of insurers to define "medical necessity" in their coverage policies.

Provision: 628.34(5m)(a)(1)(a), 628.34(5m)(a)(1)(b), 628.34(5m)(b)(2), 628.34(5m)(b)(6)
The definition of "clinician-administered drug" is overly broad (see use of "typically" as modifier that creates substantial opportunities for abuse) and specifies that "medical necessity" is determined by the prescribing provider. This definition upends long-established insurance law and regulation by creating an exception only for clinician-administered drugs. It would also grant only the prescribing clinician the authority to determine the medical necessity of a clinician-administered drug without any requirement for reference (let alone adherence) to medical evidence or clinical practice guidelines.

Changing this definition could incent providers to classify as many drugs as possible into this category to avoid health plan medical necessity reviews—essentially codifying a loophole that providers could exploit to force health plans to pay for unnecessary drugs that can be highly profitable for them. This is because Medicare reimburses providers at 106% of Average Sales Price (ASP) for the drug and its administration. Put simply, if the ASP for a

drug is $100, then the provider is paid $106 to cover both the price of the drug and administration services to the patient if the provider purchases the drug in addition to administering it.

This reimbursement requirement not only guarantees the provider is fully reimbursed for a drug's cost, but because a fixed percentage of that cost is used to pay for their services - the higher the drug's cost, the higher the reimbursement is for the administration of that service to the patient. Since many commercial plans use this reimbursement arrangement as well, efforts to control costs of both drugs and administration services have used "white bagging" to separate the cost of the drug from the reimbursement to providers. Moreover, specialty pharmacies—due to their bulk purchasing ability—can negotiate better discounts from manufacturers. This is especially important for specialty drugs, since unlike traditional medications available at retail pharmacies, there are fewer competitor drugs (like generics) available as lower cost alternatives to a prescribed specialty medication. A collateral effect of the proposed definition also strips health plans from using provider external review processes that help guard against potential waste, fraud, and abuse risks that are inherent in such reimbursement arrangements. Giving providers the role of "sole assessor" of medical necessity is a prescription for rolling back the quality of care and increased costs for all patients and payers.

Market Competition:

Individually and collectively, the provisions of SB 753 create an anti-competitive, high-cost clinician-administered drug market in Wisconsin. 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.

Provision: 628.34(5m)(a)(3)(b)

The definition of "participating provider" incorrectly assumes health insurance providers contract with all facilities or pharmacies within a health system. Under SB 753's definition of "participating provider," these non-contracted facilities or pharmacies would have to be treated the same as participating facilities or pharmacies – thereby reducing competition and interfering with freedom of contract.

Provision: 628.34(5m)(b)(4)

The broad construction of this provision suggests that a health plan could not limit coverage or require different cost-sharing for out-of-network pharmacies, which would limit competition, interfere with freedom of contract, and raise costs for patients and payers.

Provision: 628.34(5m)(b)(9)

While all of SB 753's provisions reveal an attempt to redirect clinician-administered drugs to hospital-based settings, this provision is the most difficult to view as anything other than protectionist on their behalf. Helpfully, health plans are not prohibited from using non-hospital settings for administering these drugs for patients, but since prescribers alone can determine the medical necessity of a clinician-administered drug, it would seem the use of alternative (and potentially more convenient, less-costly) settings would likely see little use. For years, other providers in different settings have dispensed and/or administered these drugs to patients safely, so it is unclear what problem this provision seeks to address beyond the presence of competitors for patients' and payers' health care dollars.

Freedom to Contract:

Today, health insurance coverage policies for clinician-administered drugs are the result of contracts that are freely negotiated between private parties. Rather than seeking a legislative remedy to contractual issues, hospitals are invited to raise concerns regarding clinician-administered drugs during negotiations with health insurance providers. Health plans welcome the opportunity to come to agreements that reduce the cost of these expensive drugs for patients, enhance patient access to care, and improve the quality of care provided without the costly interference of government contracting mandates that solely benefit the powerful hospital industry lobby over the competing interests of other health care providers.

It is not uncommon for some health insurance providers to adopt white bagging practices **at the request of providers**. For example, a provider might find white bagging preferable if they do not stock a drug due to factors such as cost or patient volume, do not have easy access to the drug, or do not have the ability to adhere to required processes for controlled substances. Under SB 753, this practice likely could not continue despite provider requests.

Conclusion:

Again, we appreciate the opportunity to share our perspective on the harmful impacts of SB 753. Clinician-administered drugs are a leading contributor to drug spending growth and only shared stakeholder responsibility will address the burden these rising costs put on patients.

Instead of pursuing legislative mandates to protect their market power, hospitals that wish to prevent health insurance providers from saving patients and employers money by pursing safe alternatives to hospital-based drug administration can do so by coming to the negotiating table and agreeing to reasonable reimbursement rates for drugs whose prices are already too high.

Contact:
Sergio A. Santiviago
Vice President, Drug Policy – Federal Programs
America's Health Insurance Plans
202.495.9407, ssantiviago@ahip.org

January 20, 2022

Marshfield Clinic
Health System

1000 North Oak Avenue
Marshfield, WI 54449

TO: Members of the Senate Committee on Insurance, Licensing and Forestry

FROM: Angelia Foster, Chief Administrative Officer, Marshfield Medical Center – Beaver Dam

DATE: January 20, 2022

RE: Support Senate Bill 753 – Protecting Patients from Mandated Insurance Practices

Chairwoman Felzkowski and members of the Senate Committee on Insurance, Licensing and Forestry, thank you for allowing us the opportunity to testify today in support of Senate Bill 753. I also want to thank Senator Jagler specifically for giving us the opportunity to meet with him in the district about this important issue this past fall.

My name is Angelia Foster and I am the Chief Administrative Officer of Marshfield Medical Center – Beaver Dam. We serve the greater Dodge County region and beyond. We provide high quality health care for thousands of patients in our community and we are an important safety net for those in our community who cannot afford life-saving medications like those that will be discussed today.

At Marshfield Medical Center-Beaver Dam we utilize the traditional buy and bill model. We purchase medications from our supplier, provide them to our patients and bill the payer for the medication/administration. This model affords us the opportunity to provide optimal care to our patients by ensuring that quality, safe medications are being provided through efficient care coordination.

At our facility we highly discourage the use of "White Bagging" for many reasons including disruptions to the traditional model described previously. We had a recent example of this at our facility when we tried to accommodate a patient that had a payer mandated "White Bagging" for their specialty medication. During the process of coordinating care, we received no contact from the specialty pharmacy providing the medication. The patient had difficulties navigating this process with the specialty pharmacy and could provide little information to our staff. We had no indication of where the medication would be shipped to and when it would arrive. Eventually the medication was shipped to our hospital, was stored temporarily in our pharmacy refrigerator and administered to the patient. However, this result occurred only after countless hours of dedicated pharmacy and nursing staff working on coordinating care for this one patient. This patient alone had to be rescheduled 3 separate times due to delays in receiving the medication.

Now imagine trying to complete this process for hundreds of patients. It's simply not scalable nor sustainable. We do not have the financial resources, staffing resources and storage capacity to effectively manage this process.

Because of these issues and the importance of maintaining the high quality of care we have come to expect in Wisconsin, I am asking you to support Senate Bill 753. Thank you for your time.

www.marshfieldclinic.org

WHITE BAGGING REMOVES PATIENT CHOICE, DELAYS PATIENT CARE

White bagging is a new tactic by health insurers, that requires certain medications to be purchased through specialty pharmacies often owned by the insurance company instead of the patient's preferred local health care provider. White bagging creates risks for patients by sourcing drugs outside the normal supply chain and quality control processes, causes patient appointments to be canceled due to shipping problems, and creates delays in medication administration, which can significantly affect patient health.

INSURANCE COMPANY-MANDATED WHITE BAGGING MODEL

Patient visits a health care provider and receives a diagnosis and prescribed treatment plan.

The health care provider writes a prescription order and sends it to the external insurer-mandated pharmacy. Begins scheduling of infusions or injection therapies for patient.

Insurer requires prior authorization. Hospital care coordinators, nursing staff and patients spend hours on the phone with insurance companies to allow patient to receive medications in the hospital. This process can take weeks.

If the insurance company continues to deny care, patient begins this process again – and has yet to receive treatment.

The external pharmacy mails the drug to the patient's provider after patients have paid their out-of-pocket costs. Hospitals bear all the responsibility of medication storage and successful delivery.

Mail delays and delivery coordination can often delay patient treatments, and even result in patients paying for drugs they never receive.

The hospital's pharmacy prepares the "white bagged" medication and reviews the patient's clinical status for changes that may impact the treatment plan.

If changes in the patient's clinical status require a different dose or different medication, this process must start from the beginning.

+ *If the health system pharmacy determines that the dosage is appropriate for the patient's clinical status, the patient receives the medication.*

TRADITIONAL MODEL

Patient visits a health care provider and receives a diagnosis and prescribed treatment plan.

The patient's health care provider uses the patient's electronic health record to conduct a comprehensive medication safety check.

The health care provider sends the patient's medication order directly to the pharmacy to ensure medication quality and availability for the patient is best to fulfill the prescription.

The pharmacy reviews the patient's clinical status and fulfills the medication order appropriate for the patient. Patients can have "just-in-time" medications from a hospital in-house pharmacy administered in a day or less

+ *The patient receives the appropriate treatment.*

PATIENTS FIRST WISCONSIN

PATIENTS FIRST WISCONSIN

White bagging causes serious, potentially dangerous disruptions to patient care and removes patient choice at the time they deserve it most. This disruption to care is happening right now to patients across the country, including in Wisconsin, because insurance companies are making decisions that belong to doctors and their patients. Lawmakers in states across the country are taking action to end the harmful practice of white bagging. **Wisconsin needs to do the same.**

Call your state lawmaker. Tell them it is time to put an end to insurance company white bagging and put patients first in Wisconsin.

PATIENTSFIRSTWISCONSIN.COM

Fort HealthCare
FOR HEALTH

The Honorable Mary Felzkowski
Chair, Senate Committee on Insurance, Licensing and Forestry
Room 415 South, Wisconsin State Capitol

January 20, 2022

Re: Fort HealthCare Support for Koreen's Law – Senate Bill 753

Chairwoman Felzkowski and members of the Senate Committee on Insurance, Licensing and Forestry, good afternoon and thank you for allowing us the opportunity to testify today in support of Senate Bill 753. My name is Carl Selvick, and I am the Senior Director of Clinic Operations at Fort HealthCare. I am here today representing Fort HealthCare and the patient's we serve in the greater Jefferson County area, that includes areas of Watertown. I am also here as a patient myself and one with a very serious disease, like Koreen, that needs and has needed expensive pharmaceutical medications to treat since I was in college. I have a severe form of Crohn's disease that is fortunately in remission because of the medication that I have to take, at this point, for the rest of my life. Prior to being in remission, I did have to let all of my college professors and clinical preceptors know about my disease as I would need special accommodations. After telling them about my condition, I would often be told stories about how they knew someone with Crohn's disease and that person always seemed to either drop out of college, was not able to work due to their disease symptoms, or had some other crippling condition from this disease. Now luckily my doctor and I did find a medication that controlled my disease symptoms and I have been in remission for over a decade. I am here testifying today because I am concerned about the white bagging requirements from health insurers and how it puts patients, like myself, Koreen, and those we, at Fort HealthCare, serve in Jefferson County at risk.

My health condition requires that I be on medication, most likely, for the rest of my life and some of the medications for my condition are susceptible to forced white bagging, very similar to Koreen. You heard testimony today on the safety, financial, and patient health risks that the white bagging requirement puts on our patients. I would just re-iterate a few of those concerns. One of the preferred treatments for my personal health condition is a clinician-administered drug called Remicade that is dosed by a patient's weight. In fact, my doctor recommended that I utilize this exact medication to treat my disease and at that time, this medication would have been white bagged. Being a pharmacist, I knew what this meant for me as a patient, and due to all of the concerns that you have heard today with these clinician-administered medications, I asked my doctor for an alternative medication to treat my condition. Luckily the alternative medication worked and I have been in remission ever since. In the end, am I on Remicade? No, I am on a different medication; however, that medication is actually quite a bit more expensive than Remicade. I mention that because one of the counter points in favor of white bagging that I have heard, is that white bagging saves patients and insurers money. In my experience that has not been the case and has actually increased the cost for both myself and my insurer.

Now let me take you through what patients like me would have to go through with a weight-based infusion medication, similar to Remicade, so you can understand why even though it was the top recommended treatment from my gastroenterologist, as a patient, I absolutely only wanted to accept that medication as a last resort. The white bagging practice creates a disconnect between the contract pharmacy that is mailing the medication directly to the hospital and the hospital that is infusing it and for medications that are dosed by weight, this disconnect can create negative financial and health implications for patients. As a patient myself, if I was ever on a weight-based infusion medication and I showed up for my infusion, my medication dose would depend on the amount that I weighed on the day of my

appointment. If my weight had changed, which does happen, what that would mean is that I may need a different medication dose. Now if the hospital cannot create the correct dose from the medication that was mailed to them, my infusion may now be delayed as I work with my contracted pharmacy to send the correct dose to the hospital. Also once a medication leaves a pharmacy it cannot be returned so most likely I would have to occur another financial charge as I work to get the correct medication dose sent to my hospital. Ultimately my health would be put at risk due to these delays in care. All because it is more profitable for my health insurance company to force me and my hospital to bypass the safety requirements that have been put in place to administer my medication safely and correctly.

I also support the brown bagging prohibition put into this legislation. The medication that I am currently taking is a refrigerated and temperature sensitive medication called Humira. This is a medication that has always been required to be dispensed from my insurer's contracted pharmacy and mailed to me each month. Now we live in WI and we are susceptible to very cold winters. I have had my medication mailed to me and by the time I arrived home from work the medication was left outside in polar temperatures for too long a period of time and was now unusable. I've also have had my medication not arrive to me on time, as it was delayed in the mailing process, which again has made the medication unusable once it did arrive. As a pharmacist I have struggled to navigate this system that my insurer has set up for me and it has led to medication errors, missed doses, and has even cost me more money when one of the contracted pharmacies refused to accept manufacturer discount cards that are used to make the medications more affordable for patients. I am told by insurers that this process they have set-up is for my benefit; however, even with my background as a pharmacist and a healthcare administrator, I fail to see how I have personally benefitted as a patient. If a person who has a doctorate in pharmacy struggles to navigate this system, It is unreasonable to expect that the every day patient can navigate this process successfully.

I will end my testimony by sharing the reality that our patients are experiencing today. Due to the concerns that you heard, many health systems have stopped allowing for white bagging to happen in their facilities, or if they do allow it, only allow it on a patient-by-patient basis. This can leave patients having to drive long distances to find facilities that allow for this practice, which impacts the patient's well-being and also impacts our area employers as these people now have to take time off work in order to get a simple medication administered. It also puts the onus on the patient to even find a facility that allows white bagging for clinician-administered medications forcing the patient to navigate this complex health care environment, instead of having us, who work in healthcare, navigate this on behalf of the patient. Our ask at Fort HealthCare is to allow us, in the industry, to pull the patients in the communities we serve out of this practice between health insurers and health systems. Require that health systems and health insurers work out their contracting agreements directly with each other and let's leave the patients out of it. No patient should be required to procure their own medication for a hospital, or infusion center, in order to get the care they need. In addition, no insurer should be allowed to deny a payment for a medically necessary, clinician-administered medication when that insurer has a direct contract with the facility that is infusing the medication. Fort HealthCare asks for your support of Senate Bill 753. As a patient, I also ask for your support of Senate Bill 753. Your vote can ensure that the patients that we, at Fort HealthCare, serve will continually have access to the life-saving medications that their doctor has prescribed.

Madam Chair and Senators, thank you for your time today.

Sincerely,

Carl Selvick

Carl Selvick, PharmD, MBA, FACHE
Senior Director Clinic Operations
Fort HealthCare

Cc: Members; Senate Committee on Insurance, Licensing and Forestry

Congressional Hearing
Matt Ohrt Talking Points - Team Schierl Companies

- *Thank you for your time today to listen to all perspectives.*
- *On a personal note, I am a private industry executive, with experience in manufacturing and retail. I have served:*
    - *VP of HR & Medical Services at Merrill Steel in Schofield*
    - *Currently, I work for Team Schierl Companies in Stevens Point (60 convenience stores, Subway restaurants and tire centers, and 700 associates)*
- *Simultaneously, for the past 6 years, I founded and have led a healthcare best practice group in Central Wisconsin, made up of 50 employers and 150 providers. We are gaining new members rapidly. With healthcare costs rising at unsustainable rates, there is strong interest by employers to manage costs and provide sound benefits to their employees.*
- *For this work in healthcare reform, I was given the following award:*
    - *Central Wisconsin HR Professional of the Year award in 2019*
    - *Healthcare Innovation Award in 2020*
    - *National Employer/Purchaser Healthcare Excellence award in 2020. (previous winners Disney, Boeing, and Walmart)*
- *My wife and I live in Mosinee and serve as Champion Foster Parents for Marathon County and we are actively adopting children out of the system. In 2018, we founded a nonprofit foster child supply closet. In 2020 we were given the Governor's Foster Parents of the Year award for our charity work.*
- *I must share that I am concerned about this bill. Although being presented differently, this is another attempt to monopolize healthcare and restrict healthy competition. Unbeknownst to the public, most of the hospital systems are riding a gravy train, on the backs of regular, hard-working citizens and employers. With misaligned incentives, all three of these entities make more when costs go up. For them, healthcare is not broken - it is working just as intended.*
- *Little concern seems to be given to the payers of nongovernment healthcare – employers, employees and their respective families who make up the communities of Wisconsin. I care about Wisconsin communities and am concerned about entities that present themselves as valuing patient care, but often act incongruently. Let's see this accurately. This bill is not really about patient care. It's about monopolizing yet another piece of healthcare.*
- *For most Wisconsinites, healthcare plans have become unaffordable and no longer protect a family. The last time we looked it up, 400 families were sued for healthcare bills in a 90-day period by one local system! You can go on to C Cap and look it up yourself. It is disturbing how many lawsuits there are from nonprofit hospitals against the families and communities.*
- *American Medical Journal (AMJ) Public Health research indicates that **2/3 of bankruptcies are related to healthcare and 3/4 of those families had health insurance. Further, by 2030, the average American family of four healthcare spend is expected to be 52% of household income.** That doesn't leave much remaining for other important expenses, such as a home mortgage payment or an automobile payment. The oath of **"Do no harm"** should also apply to a family's financial stability. Overcharging, followed by garnishment of wages and liens on homes is harming our communities greatly.*
- *As purchasers of healthcare, we are in a vulnerable position. The only successful strategy for survival is to avoid the use of hospital systems, whenever possible. Recently, I called a local provider for a price estimate who repeats the same procedure over 10 times per day and was told it is "too complicated", and to call Aspirus, who has them under contract. I wondered – how do they know what to bill if they don't know the price? I wondered if they were being honest with me.*

- *As a better path, we partner with many independent primary care clinics, imaging, surgery, oncology, and cardiology centers, and the like, who give me one fair price for a specific procedure. We don't talk in "insurance code", rather we talk in understandable bundled prices – at rates that are about a quarter of the cost of hospital systems – with a level of quality that is second to none.*
- *In conclusion, if we are talking about a pharmacy bill that further monopolizes healthcare for wealthy hospital systems, this will handcuff the free market even further and based on what I have learned about the gravy train and how much I care about Wisconsin communities; I cannot support one ounce of it. It will fail the "Do no harm" test for families – both financially and in quality of care.*
- *What Wisconsin communities need is a different kind of legislation – legislation that takes us from the current monopolized, pseudo free market, to a true free market; one in which patients can evaluate cost and quality and make a good choice. One entity or type of entity having control of a certain product or service always leads to price inflation, and ultimately price manipulation, as we have seen in dramatic fashion with hospital system healthcare over the past 20 years, resulting in an unsustainable path. If you pass this bill, I assure you that will happen, and it will be another feather in the cap for already wealthy healthcare systems and big pharma. And those sure are expensive feathers.*
- *I appreciate your time today. I have included an example in my written testimony that will help explain how healthcare works in a pseudo, restricted free market. Please feel free to reach out to me for discussion.*

If Construction Worked Like Healthcare

Here is an example to illustrate how important it is that we unlock the handcuffs of the free market. Many years ago, while attending college for 7 years, at the age of 19 I started and ran a construction business. I wore all the hats, from estimation to project completion and had a small crew to help me. Imagine, if you will, if construction worked like healthcare.

A summer thunderstorm rolls through and you notice that there is water dripping from your kitchen ceiling. You think to yourself; I can't really afford this. I have kids in college and tuition bills to pay, but you know it can't be ignored. You realize you need to call a contractor, and you learn from your homeowner's association that Community Care Roofing company is the only contractor approved for your neighborhood. You are concerned. How can I get a fair price if there is only one contractor? You figure, with a name of Community Care, they must be good, and you call for an estimate. You are comforted more to learn that the organization is a nonprofit entity, created to serve the public. You even take a minute to check out their website, and their stated values are integrity, transparency, community, and charity. You sleep well that night.

The contractor shows up and you begin to tell him about the roof leak. He doesn't listen and only wants to confirm what insurance you have. You give him that information and he agrees to look at your roof. You may or may not need a whole new roof, but he made the trip, so he recommends one. He proceeds to measure and talk with you about shingle style, warranty, and color preference. He finishes, and before he leaves, you ask if he will be sending a quote. He smiles and responds that it is "too complicated", and he will be there in a couple weeks to begin. You think, that is frustrating and a little scary, but this is how everyone does this, so you go along with it. You see Community Care in colorful vinyl, all professional-like, on the big expensive truck and everything looks legitimate, so you brush it off and go inside.

A month and a half later, he finally shows up with his crew and they begin tearing off your roof. You don't really understand construction, but trust that they know what they are doing. You are at their mercy at this point, and you hope for the best. They perform the work and in about a week, the old roof is off, in the dumpster and the new roof is on, and looks good. You sign all the papers, and he gets in his shiny truck, smiles,

and says he will send you the bill. Before leaving, he says you need some other things, and refers you to a gutter installation company and siding company. He says if you don't get those things done your house will really be at risk. For the roof bill, you're not sure what to expect, but you are guessing it will be $7,000 to $8,000, because you only have a smaller, one story ranch home. Over the next few weeks, you keep looking for a bill. Nothing comes, so you continue to wait. A couple months later, it arrives. It is from the delivery company for the shingles. A few days later, you get another bill from the same delivery company for felt and nails. You think, that is weird, why didn't they deliver it in one trip and why it is my cost if they didn't? No one asked me. And more concernedly, the bill for the shingles arrives and it is $12,000, and yet another one arrives for felt and nails and it is $4,500. A few days later you get a bill for the labor, and it is $22,000. You call the contractor and he is annoyed that you are asking. He says not to worry - insurance will cover it. A few day later you get a bill for the dumpster, and it has a surcharge on it because the roads were slippery that day. And the next day, you get another bill for the removal of the roof. You call the contractor again and mention that you thought that was covered in the first labor bill, but he exclaims that is a different department. A day later you get another bill for roof sheathing repair and one sheet of plywood was used. The charge for the plywood is $1496. You call once more to ask questions. The contractor is increasingly annoyed and short tempered that you are questioning him. You explain that you can get this sheet of plywood for $42 at Home Depot. He doesn't acknowledge your shopping acuity and tells you insurance will cover it. You wonder what you will do. You only have $3,500 in your savings. While you are stressing about the bills, a collection letter shows up, threatening to take you to court if you do not pay promptly. You remember a friend telling you that he had his wages garnished and a lien placed on his home for not being able to pay. Finally, the bills stop. You also learn that your insurance company is now questioning whether a second delivery for materials is covered. It was not preauthorized beforehand. After about 8 phone calls, insurance finally agrees to pay for the extra delivery. The total of the bills comes to $52,569.24 and your home deductible is $10,000. Thankfully, you have built up your 401k and decided to take a loan through your employer. You take the money out and pay your maximum out of pocket for the year. Your bank account is empty, and your retirement took a hit, but everyone got paid and you are thankful you didn't have to file bankruptcy. Hopefully, no other surprises come up.

Unfortunately, this is not an exaggerated story. This is how healthcare works every day in America. Please consider this if you decide to handcuff the free market further.

Westfields Hospital & Clinic

HealthPartners®

Testimony before the Senate Committee on Insurance, Licensing and Forestry

2021 Senate Bill 753 – "Koreen's Law"

January 20, 2022

Steven Massey, President
Westfields Hospital & Clinic / HealthPartners

Chairwoman Felzkowski and members of the Senate Committee on Insurance, Licensing and Forestry, thank you for allowing us the opportunity to testify today in support of Senate Bill 753. My name is Steven Massey and I'm the President at Westfields Hospital & Clinic which is a Critical Access Hospital located in New Richmond. Westfields is part of HealthPartners, which is an integrated health care organization providing health care services and health plan financing and administration. We operate three hospitals and 7 clinics in Western Wisconsin providing care to over 75,000 patients. HealthPartners health plan insures over 65,000 members in Wisconsin. In addition, HealthPartners employees over 1,300 residents of Wisconsin.

As already noted, I am here today to testify in support of Senate Bill 753 which has taken on the name of Koreen's Law. The practice of white bagging results in significant problems for both patients and providers. Not only are there serious patient risks associated with this practice, it shifts costs onto patients and providers. These problems can impact patient care and cause serious harm which is why I am here to support this piece of legislation. You have heard about some of these concerns today related to delays due to the wrong drug being delivered, delays in the drug being received, appointments then needing to be canceled, drugs having to be wasted, delayed treatment, additional administrative staff needed at hospitals and clinics to manage the process, and the fear and anxiety felt by patients as they are caught in the middle. Our site is the hub for the Cancer Center of Western Wisconsin and we see a large volume of infusion patients. We have seen specific cases of these delays taking place within our care system and are very concerned about the increase in these practices and the risks it places on our patients. Also of note, as a health plan, we do not practice white bagging.

Focusing on safety, outcomes, cost, and value can be achieved through the normal contracting process between providers and health plans. I ask for your support for Senate Bill 753.

Thank You,
Steven Massey
President
Westfields Hospital & Clinic
Cc: Members; Senate Committee on Insurance, Licensing and Forestry

MWFPA
Midwest Food Products Association, Inc.

TO: **Senate Committee on Insurance, Licensing and Forestry**

FROM: **Jason Culotta**
President
Midwest Food Products Association

DATE: **January 20, 2022**

RE: **Opposition to SB 753 – Ban on "White Bagging"**

The Midwest Food Products Association (MWFPA) appreciates the opportunity to comment on Senate Bill 753. Our objective is to keep health care affordable for employers to continue providing quality employee coverage.

MWFPA is the trade association representing food processors and their allied industries throughout Illinois, Minnesota, and Wisconsin. Our members operate 40 production facilities in Wisconsin including nearly all of the state's vegetable canners and freezers.

SB 753 aims to prohibit "white bagging" and other health care cost control measures.

"White bagging" refers to the delivery of a specialty prescription drug by an insurance company to a provider rather than having the same drug purchased by a provider. In either case, the specialty drug is administered by credentialed provider staff to the patient.

Under white bagging, providers are disappointed with the small administration fee they are paid by insurers to administer the specialty drug while insurers are unhappy with the often significant markup that providers add before the patient is billed for receiving the drug.

Instead of allowing the health care industry – providers and insurers – to work out their differences, this legislation has been introduced to deliver a decisive "win" to one of the parties by approving the significant markups added by providers to the cost of specialty drugs.

As a trade group comprised of many self-insured insured employers, our Association is compelled to engage in this health care industry dispute. Our primary concern is that the Legislature will tip the scales of this particular balance and compel the cost of specialty drugs to artificially rise by enacting this bill.

Banning "white bagging" will not help employers continue to provide health coverage to their workers.

On behalf of maintaining employer-sponsored health coverage, we ask that you reject this legislation.

Thank you for providing the opportunity to comment.

Midwest Food Products Association ■ 4600 American Parkway, Suite 210 ■ Madison, WI 53718
(608) 255-9946 ■ www.mwfpa.org

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AND INDEPENDENT BUSINESSES

January 20, 2022

TO: **Members**
Senate Committee on Insurance, Licensing and Forestry

FR: **Brian Dake**
President
Wisconsin Independent Businesses

RE: **2021 Senate Bill (SB) 753 relating to: prohibiting certain practices relating to insurance coverage of clinician-administered drug**

Madam Chair and committee members my name is Brian Dake, President of Wisconsin Independent Businesses. Thank you for the opportunity to testify in opposition to 2021 Senate Bill (SB) 753.

By way of background, Wisconsin Independent Businesses (WIB) was formed in 1977 to provide small, independent business owners with an effective voice in the legislative and regulatory activities of state government. Today, we proudly represent more than 2,000 small business owners throughout Wisconsin. Most of our members (approximately 85%) own and operate businesses that fit within the legal definition of a small business – fewer than 25 employees and/or annual gross revenues of less than $5 million.

It has been more than a decade since the Affordable Care Act (ACA) became the law of the land. Unfortunately, the promise of affordable health care coverage remains unfulfilled for many small employers and their employees. Employer-paid premiums and the out-of-pocket expenses their employees pay continue to rise. These troublesome trends are becoming even more problematic as the Wisconsin labor market continues to shrink.

Highly qualified, experienced, and well-educated workers have many employment options. They are more likely to seek employment with a company that can offer them a benefit package that includes employer-sponsored health insurance coverage. Large employers are better positioned to do so. Small employers cannot ignore this marketplace reality if they want to retain or hire the workers they need.

Increased utilization of prescription drugs, and in particular specialty drugs, is a significant health care cost driver. According to an April 20, 2021, press release from the American Society of Health-System Pharmacists, "the growth in spending on specialty drugs continues to outpace the rest of the market and could exceed 50% of overall drug expenditures in 2021."

In response, health insurers have instituted an alternative sourcing practice for specialty drugs in limited circumstances when there are significant cost savings for patients and employers, and when clinical evidence indicates the specialty drug can be safely dispensed and are appropriate for the patient's needs.

SB 753 would eliminate this market-based, cost-saving practice thus driving up the cost of health care coverage for Wisconsin small businesses and their employees.

Furthermore, Wisconsin small employers are at a competitive disadvantage when they cannot offer their employees and prospective workers access to high-quality affordable health care coverage. From our perspective, enactment of SB 753 would make it even harder for Wisconsin small businesses to retain and hire the workers they need.

We respectfully ask for your opposition to SB 753.

Thank you in advance for your consideration.

Date: January 20, 2022

To: Members of the Senate Committee on Insurance, Licensing, and Forestry

From: Dr. Julie Mitchell, Regional Vice President and Senior Clinical Director
Elisabeth Portz, Senior Director of Government Relations - Wisconsin

Re: Senate Bill 573 – Oppose

We would like to thank Chairman Felzkowski and members of the Senate Committee on Insurance, Licensing, and Forestry for the opportunity to speak today about Anthem's concerns regarding SB 753, legislation prohibiting certain practices relating to insurance coverage of clinician-administered drugs.

Anthem in Wisconsin

For more than 80 years, Anthem Blue Cross Blue Shield has proudly served the people, employers, and communities of Wisconsin. Today, over one million Wisconsinites carry the Blue Cross and Blue Shield card and we employ 1,150 associates statewide.

Anthem Blue Cross Blue Shield in Wisconsin is a part of the national Blue Cross Blue Shield Association, a federation of 35 independent and community-based companies that collectively provide health care coverage to one in three Americans. Importantly, Anthem's participation in the Association ensures our Wisconsin members enjoy access to affordable healthcare throughout the country. It also means that members of Blue Cross Blue Shield plans in other states have access to our doctors and hospitals when living in and travelling to Wisconsin.

Anthem's Focus on the Triple Aim and Affordability of Specialty Drugs

Fifteen years ago, the Institute for Healthcare Improvement launched the triple aim initiative, providing a compass to define success in population health. The triple aim combines the three goals of achieving health in a population: one, access to health care when needed, and two, delivering care that results in improved health. These two parts (*better care* and *better health)* focus on healthcare delivery. But the needs of the people we serve go beyond health care delivery, so the triple aim adds to *better care* and *better health* with the third aim: *lower cost*.

We know that cost is part of healthcare quality. From the Kaiser Family Foundation: "Half of U.S. adults say they put off or skipped some sort of health care or dental care in the past year because of the cost. Three in ten (29%) also report not taking their medicines as prescribed at some point in the past year because of the cost."[i]

Physician administered drugs are those prescription drugs that are administered by a health care provider to a patient through injection or infusion and can also be administered in a hospital outpatient setting or a provider's office. Specialty drugs treat a wide range of conditions, including inflammatory conditions, oncology, HIV, and multiple sclerosis. Specialty drugs can cost tens of thousands of dollars per month and are the largest driver of rising drug costs for consumers and employers. In fact, specialty drugs account for only 2% of drugs dispensed[ii] but represent nearly 45% of all prescription drug spending,[iii] a figure that is expected to rise to 52% by 2024.[iv]

Contributing to those rising costs, providers often charge 200% to 300% more for certain specialty drugs administered in some outpatient hospital settings than when the same drug is administered in an office setting, with some providers charging over 500% more. Anthem's specialty drug network initiative plays a vital role in helping members who need specialty drugs continue to receive the same high-quality drugs at more affordable costs.

Prioritizing Access to Affordable Specialty Drugs through Collaborative Solutions
In April 2021, to address this fast-growing problem of skyrocketing specialty drug costs, Anthem began working with its 149 provider partners in Wisconsin on an initiative that would help us do just that. Anthem's goal was and is simple: ensure safe, reliable access to these drugs for our members without unnecessarily increasing costs for consumers and employers.

To do this, Anthem has implemented a designated specialty pharmacy network for a small subset of specialty drugs that are administered in a physician's office or outpatient hospital setting and are included in *a member's medical (not pharmacy) benefit*. This initiative requires our provider partners to acquire these drugs from CVS Specialty, the country's leading specialty drug's supplier.

CVS Specialty has more than 30 years' experience in specialty drug business and has access to the same high-quality drugs often at a more affordable price. CVS Specialty delivers the specialty drugs directly to care providers when and where they are needed. As many of you know, this process is sometimes referred to as "white bagging."

If a provider partner does not want to receive this small subset of drugs from CVS Specialty, Anthem works with the provider to join its specialty network by arriving at a mutually agreeable and reasonable price markup charged by hospitals for these drugs, known as "buying and billing." It is important to note that additional costs to administer these drugs are reimbursed separately and in addition to the cost for the drug. It cannot be understated that our provider partners are all given a choice. If they would like to continue buying and billing, they absolutely can do that as long as they negotiate a fair and reasonable rate for those specialty drugs.

This initiative went live in July 2021. In the vast majority of cases, Anthem's healthcare provider partners continue to order and administer these drugs exactly as they did previously. Of Anthem's 149 provider partners, only 6 hospitals are choosing not to work with us, and they are all from the same hospital system.

Building a Program with Attention to Quality and Access
Anthem built a specialty pharmacy network to address affordability, while maintaining high standards for quality and access to these lifesaving drugs. First, Anthem picked an industry leader as our pharmacy partner, for those hospitals that did not want to join our specialty pharmacy network. As experts in drug ordering and delivery, CVS Specialty prioritizes shipments based on the member's infusion date. They work closely with the member and care provider to deliver the specialty drugs when and where it is needed for administration to the member. CVS follows all required safety checks and is willing to work with hospitals in medication tracking to match the hospitals' additional safeguard protocols, such as drug interaction assessments and double-checking appropriate dosage for the patient's weight.

However, if CVS Specialty is unable to provide the drug on time or in the dosage needed, or a medical emergency arises, Anthem has an exception process in place that allows for providers to use the needed drug from their own shelves and bill Anthem for that drug. It should be noted that Anthem has not

received a complaint from our providers statewide regarding delay of delivery through this program. These exceptions ensure that the member's care team and attending physician are able to initiate needed treatments in a timely manner. Anthem allows providers to determine if a treatment is needed because of an emergency or an inappropriate delay at the point of care. In other words, this initiative does not make any changes to current prior authorization practices and exceptions are granted without express prior approval.

Anthem's Concerns with SB 753

Because of the reasons above, Anthem must oppose SB 753. The health and safety of our members is at the heart of what we do at Anthem, and this legislation will remove our ability to prioritize the triple aim of better care, better health, and lower cost.

Affordable and equitable access to quality healthcare must be a primary goal of our entire healthcare system. Unfortunately, this legislation would block a program that safely and dependably assures access to life-saving specialty drugs, and helps protect Wisconsin consumers and employers from unsustainable healthcare cost trends.

Thank you again for your time and consideration on this legislation. We are always available to answer any questions legislators and staff may have regarding Anthem's initiative in Wisconsin.

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[i] Kaiser Family Foundation: Americans' Challenges with Health Care Costs (December 14, 2021): kff.org.

[ii] IQVIA: Medicine use and spending in the U.S. (May 9, 2019): iqvia.com.

[iii] Managed Care: Specialty drug spend soars. Can formulary management bring it down to Earth? (September 18, 2019): managedcaremag.com

[iv] IQVIA: Global medicine spending and usage trends: outlook to 2024 (March 5, 2020): iqvia.com

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Testimony before the Senate Committee on Insurance, Licensing and Forestry
2021 Senate Bill 753 – "Koreen's Law"
January 20, 2022

Sarah Jensen, MSN, RN, OCN- Director of Hematology & Oncology
Bellin Health

Chairwoman Felzkowski and members of the Senate Committee on Insurance, Licensing and Forestry,

Thank you for providing the opportunity to testify today in support of Senate Bill 753. My name is Sarah Jensen and I am an Oncology nurse by trade. I am currently the Director of Oncology & Hematology at Bellin Health in Green Bay and I am responsible for all of our outpatient infusion services within the system. Today, I'd like to emphasize the critical nature of standardization and processes as it relates to the safety of infusion patients.

I want to start by describing at a high level, what transpires in our centers on a day-to-day basis. We have hundreds of providers placing orders for medications. Our infusion locations receive these orders and conduct financial discovery and authorizations. Once approved, patients arrive and have their blood drawn as most of these medications require close monitoring of lab values. Pharmacists review patient labs, verify drug indications, communicate with ordering providers as necessary, etc. The pharmacy technician compounds the drug and the pharmacist verifies appropriate dose/compounding before the drug is transported to the infusion space. The infusion nurse verifies the correct drug/dose/patient/route and administers the medication. The facility must have nursing, pharmacists, and MDs available for adverse drug reaction management.

We as healthcare systems are responsible for the safety of the patient. Every step of this process requires clinical experts, equipment/resources, time, and standardization. We take this responsibility extremely seriously and commit extensive resources to ensure that safety.

Our contracted vendors have designated delivery times, locations, and expectations. We know exactly every medication sitting on our shelves and when we will need our next shipments—we know where these shipments are coming from, we know where/when they'll be delivered, and we have a plan for storage at the appropriate temperatures or conditions as soon as they arrive.

If we add white-bagging to this process—we are adding significant variation and risk on the front end and reducing the ability of the health care providers to guarantee the safety and integrity of the medication that hospitals and ordering providers are still 100% responsible for.

Every patient whose insurance forces a white bagging requirement, does so with different rules, processes, and expectations. For example, sometimes the first dose can be dispensed by the in house pharmacy but the subsequent doses must be sent from an external location. Some specialty pharmacies require the patient to call prior to their appointment to initiate shipment, while others allow the health system to do the calling.

Each of our locations that manages white-bagging requires additional staffing hours to navigate these significant intricacies. For each white bagging patient, the health system incurs an additional 2-4 hours of labor per week between pharmacy, financial, and nursing to coordinate ordering, delivery, scheduling and coordination of care. An extensive amount of time is spent on the phone between insurance companies, specialty pharmacies, and the patient.

When a drug is white-bagged, it arrives via varying transport companies. The facility may or may not routinely work with these delivery staff. This results in drug deliveries in off hours, at wrong facilities, and drugs being left in the wrong conditions. We have had white bagged medications delivered to wrong sites during hours when the pharmacy is not even open. This results in drugs sitting on counters for hours or days until recognized as a wrong delivery; such as a recent delivery to an urgent care site rather than a pharmacy site. Think of it like this, the delivery company responsible for your personal online orders is the same delivery truck that may drop off a medication to one of our sites; often regardless of day, time, or signature.

Variation in operational processes affects patients. Last month, our infusion center was contacted by a patient receiving an infusion treatment for a digestive health condition at a neighboring health system. This patient's insurance carrier recently changed a policy and refused to allow that health system to continue administering their own stock of the medication; this organization, understandably, declined to white bag due to the risk involved. The patient then called our facility. We informed him that we do allow white-bagging but that his medication must be ordered by one of our specialists for us to agree to this form of drug acquisition, again, due to the already complicated process it creates. Because this patient's insurance would not allow an in-network provider to provide the full service of infusion, this patient not only had to switch infusion facilities, he had to re-consult with a GI specialist and re-develop his entire plan of care, all so that his insurance company could dictate where the drug was purchased.

As you can see, white bagging has the capacity to increase patient safety concerns related to the integrity of the medication, create significant delays in care, and cause extreme stress for patients who rely on the timely administration of these medications to maintain their quality of life. In support of our patients and the patient stories we did not get to hear today, I respectfully ask for your support of Senate Bill 753.

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January 20, 2022

Testimony to the Senate Committee on Insurance, Licensing and Forestry
Support for Senate Bill 753
Arlene Iglar, RPh, M.S., FASHP, Vice President of Pharmacy Operations
Mark Hamm, PharmD, MBA, Director of Pharmacy Oncology
Lora Dow, Manager of Oncology Services

Chair Felzkowski and members of the committee – thank you for the opportunity to provide testimony in support of SB 753. Thank you also to the bipartisan bill authors and cosponsors for prioritizing this important legislation.

My name is Arlene Iglar and I am the Vice President of Pharmacy Operations for Advocate Aurora Health. Advocate Aurora is the state's largest integrated delivery system, employing more 40,000 team members, including 3,500 physicians, 10,000 nurses and over 500 pharmacists. In Wisconsin, our integrated delivery system has 16 hospitals, 150 clinics, 70 pharmacies, and we serve nearly 1.2 million patients annually.

I am here today on behalf of Advocate Aurora, along with my colleagues Mark and Lora who will speak momentarily in support of SB 753.

White bagging is a growing problem that we are seeing more frequently throughout our health system in Wisconsin. These policies interfere with care delivery to patients, require extensive amounts of time for logistical planning by our staff, and introduce unnecessary safety risks. All to source a drug that we already have on hand in our on-site pharmacy.

These policies are bad for providers, but even more importantly they are wrong for patients, most of whom do not even realize until they have a major health issue that they have to jump over these hurdles to get their medication. They understandably assume that "in network" means they have access to our pharmacies. Unfortunately, white bagging restrictions mean that when our patients need help the most, we sometimes cannot be there to provide the needed care for them.

To highlight some process problems caused by white bagging, I will turn it over to Mark Hamm.

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Thank you Arlene, and members of the committee. I am Mark Hamm, Director of Pharmacy Oncology for Advocate Aurora.

In that role, my team and our patients experience the consequences resulting from white bagging requirements. There is often a lack of coordination between the specialty pharmacy and receiving pharmacy that can lead to treatment delays. Here are just two examples.

Recently, one of our pharmacy technicians was told a white bagged medication would be delivered to her pharmacy. She saw the patient was scheduled but had still not received the drug. She called the specialty

pharmacy and learned the patient needed to contact the specialty pharmacy to pay the co-pay and authorize the release of the medication. During that call, the pharmacy technician learned the medication was sent 10 days prior but was sent to a different pharmacy in our health system. This patient was delayed by over 10 days.

This scenario would not happen under our normal process. The medications we purchase generally arrive at the same location at approximately the same time each day. The ordering process from a medication wholesaler to a pharmacy is direct, making it easier to identify which medications were delivered versus which medications were ordered. This enables us to maintain our inventory to treat the patient on the day they are scheduled.

Another problem we've experienced with white bagging involves drugs in which the dosage can change based on the patient's weight on the day they are treated. There have been numerous times that a patient is weighed on treatment day and based on that weight the dose increases, but the amount shipped for the patient will be insufficient. This causes the patient to be treated with a suboptimal dose or to delay treatment until the remaining quantity shipped. Again, this problem would not occur under our standard process since we could normally use medication in our inventory to be able to accommodate weight-based dose changes. And again, it is the patient who pays the price.

Unfortunately, these are just two examples that illustrate the consequences of interrupting our pharmacy workflow. As the prevalence of white bagging has increased, we have also tried to adjust by reallocating staff resources. For more on that, I will turn it over to Lora Dow.

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Thank you Mark and committee members. I am Lora Dow, Manager of Oncology Services at Advocate Aurora.

As we experienced more instances of white bagging, our Oncology service line has attempted to streamline the process and minimize impact on patients by transitioning one of our FTEs into a role primarily supporting this complex process. Her duties over the past few years have changed significantly as she works specifically with the Oncology infusion centers, specialty pharmacies and patients to coordinate shipments.

But as Mark mentioned, even with enhanced coordination, we still experience frequent issues with delivery delays, incorrect shipping and dosing changes. There are just too many different people and departments involved for this process to be successful. I would like to share two specific patient examples showing how white bagging has led to interruption in care delivery in my department.

In the first example, this patient is a 78-year-old gentleman who has a chronic leukemia. He receives an infusion every 4 weeks to assist with his compromised immune system. He was scheduled to receive his next IVIG infusion, however, it had to be rescheduled because his insurance is now requiring this infusion to be filled at a specialty pharmacy.

Our preservice department was alerted to this requirement, the charge representative was then involved to initiate delivery, the team nurses helped to get the medication orders from the provider sent over to the specialty pharmacy and the patient was contacted by the specialty pharmacy to arrange payment. The most recent message our office received from this patient states that he needed to reschedule his

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IVIG infusion again because he is waiting for copay assistance. His cost is $7,750 and he cannot afford this and has applied for a copay assistance fund. He hopes to have an answer on whether he qualifies for that assistance by next week.

For this particular patient – if he were not required to fill through the specialty pharmacy, his medication would have been administered on time, and his care would have been billed through his medical insurance, not his pharmacy benefit.

The second example: our patient is 50 years old and has an autoimmune disorder for which she receives an infusion every 4 weeks. Her medication is required by her insurance to be filled through a specialty pharmacy. Each time her medication is filled, the pharmacy must reach the patient to get authorization and payment. The patient is working a full-time job and it is difficult for her to connect with the pharmacy to authorize payment and shipping – leading to delays.

In reviewing the last year of appointments for this patient, half of her appointments had to be rescheduled due to shipping delays. This impacts this patient because first, these are days and times that she has to arrange to take off of work for her infusions that then also need to be rescheduled. In addition, with these autoimmune disorders, once a patient is on a maintenance therapy, their symptoms can be well controlled. However, when the treatment is delayed, their symptoms can flair up and this can impact their quality of life, ability to work and function and can also lead to them having to seek out medical care to regain control of symptoms.

All of these examples are just a glimpse into recent experience with white bagging, a process that interrupts coordinated care and delays treatment, among other problems. We again thank the bill authors for bringing this important legislation forward, and respectfully ask this committee to please support SB 753.

Thank you for the opportunity to testify and please let us know if you have any questions.

Ascension

Testimony before the Senate Committee on Insurance, Licensing and Forestry

2021 Senate Bill 753 – "Koreen's Law"

January 20, 2022

Testimony provided by Vanessa Freitag, Vice President of Pharmacy and Lab and Lisa Gilbert, Supervisor of Oncology Financial Support, on behalf of Ascension Wisconsin

Dear Chairperson Felzkowski, Vice Chair Stafsholt and Members of the Committee:

My name is Vanessa Freitag and I serve as Vice President of Pharmacy and Lab with Ascension Wisconsin. Ascension is a faith-based health care organization committed to delivering compassionate, personalized care to all, with special attention to persons living in poverty and those most vulnerable. Serving Wisconsin since 1848, Ascension operates 17 hospital campuses, more than 100 related healthcare facilities and employs more than 1,100 primary and specialty care clinicians from Racine to Appleton.

I am here today, on behalf of Ascension, to express support for SB753, also known as Koreen's Law, which seeks to end the harmful practice of "white bagging" in Wisconsin. This emerging insurance practice requires that certain medications, typically provider-administered IV or injectable medications, be purchased and dispensed separately through a third party pharmacy, and then sent to the patient's provider to be administered in a clinical setting.

This practice:

- **Disrupts best practices** in the pharmaceutical supply chain safety protocols,
- **Creates significant delays** and interruptions in care,
- **Requires patients to pay** sometimes exorbitant, upfront co-payments before they can receive care, and
- **Creates immense confusion** for patients who must navigate an overly bureaucratic process of ordering the life-saving medications they need through an outside third party specialty pharmacy.

SB753 would **prohibit** this practice and ensure that patients can access needed medications through their health care provider, benefit from discount and financial assistance programs offered through hospitals and maintain the continuum of care.

Ascension Wisconsin encountered the emergence of white bagging in early 2020, when we received notification of changes to drug coverage through a quarterly managed care communication bulletin. White bagging policies have been communicated inconsistently, and are outside of negotiated agreements. As a result of the lack of transparency, Ascension Wisconsin care team members often have little time to prepare and proactively assist impacted patients. Because "white bagging" is currently focused on medications administered through an IV or infusion, the patients who are impacted most by these changes are often medically acute patients who are in the midst of treatment for a range of serious chronic conditions including neurological diseases or acute illnesses such as cancer. This is unacceptable.

Ascension Wisconsin clinicians, pharmacists and patient advocates have witnessed numerous incidents in which white bagging has had a tremendously negative impact on patient care. Below are representative examples of how this practice causes delays and interruptions in care and life-saving treatment.

Patient Financial Burden: Third party pharmacies are requiring our patients to pay their copayments **prior to** the shipment of their medication. Additionally, our patients are reporting that they are not being offered or directed to financial assistance programs for which they may qualify. This not only creates financial hardship for patients juggling multiple medical expenses, it can delay care for individuals with financial limitations and who cannot pay upfront. By contrast, when patients receive their medications in the hospital setting, they are provided with care first. The hospital Financial Advocates offer patients support they need to pay for care, including assistance applying for drug discount programs and charity care benefits. Ascension is committed to providing personalized, compassionate care to all patients, regardless of their ability to pay..

Limited Access Pharmaceutical Discount Programs: Many third party specialty pharmacies do not offer patients guidance or assistance when applying for the drug discount programs for which they qualify, causing them to miss out on crucial savings for costly medications. We also have encountered instances when specialty pharmacies have refused to honor pre-approved pharmaceutical discounts that patients have attained with the help of our staff. This is simply unacceptable. Ascension Wisconsin care team members assist our patients in navigating the confusing process of applying for drug discount programs as a standard of care. We seek to help

patients mitigate financial challenges and ease their stress. Shouldn't all providers involved in the chain of care have these goals at the center of their philosophy?

Duplication and Errors in Medication Orders: Patients are being asked to navigate the orders for their medication through third party specialty pharmacies, when they should be focused on their health. Their Ascension Wisconsin care team considers placing orders as part of the services we provide. Some of these patients are cognitively impaired, in the advanced stages of their disease and cannot manage this responsibility on their own. This often results in wasteful duplication of orders, as well as erroneous medication orders. Once the medications have been ordered incorrectly, patients are held financially accountable for these mistakes or have delays in care, as medications cannot be returned or quickly replaced once they are delivered to hospitals. Patients often have labs drawn the same day as treatment and may have medication changes as a result. Hospitals can quickly pivot to the new therapy plan. White bagging does not allow this.

Supply Chain Safety and Efficiency: While we have many concerns regarding the overly burdensome process of coordinating medications through white bagging, I'd like to highlight two specific items:

- White bagging is inefficient and adds costs for healthcare providers. Once medications arrive, providers must store white-bagged medications in segregated space to ensure they are not commingled with existing stock, because specialty pharmacies require that the pharmacy may only use the medication for the specific patient for whom it was dispensed. While this requirement is appropriate, it results in a tremendously inefficient practice and requires significant changes in our storage and tracking processes.
- Most concerning, however, is that specialty pharmacies are not adhering to scheduled delivery times. As a result, we receive more packages, at varying times of day, delivered to incorrect locations. This variability creates greater risk of improper medication storage, disruption to established workflows and increased likelihood of miscommunication, waste and error.

While I've talked about how white bagging is inefficient and challenging for healthcare providers, the negative impact falls heaviest on our patients. Lisa Gilbert is here with me today to offer background about our patient experiences.

I am Lisa Gilbert, I serve as Ascension Wisconsin's Supervisor of Oncology Financial Support. My team offers direct support to patients who are experiencing challenges first hand. I would like to offer a few stories about patient experiences.

Patient with Autoimmune Disease Denial of Coverage: One of our patients with an immune deficiency disorder was undergoing immunoglobulin treatment with his Ascension Wisconsin provider for several years, then changed insurance coverage in January 2021. On July 5, 2021, the patient's medication claims were denied by his managed care organization. Because of this denial, the patient delayed care out of concerns about the financial cost if the medication was no longer covered by the insurance company. This was the only treatment option available for this patient. After months of negotiation with the patient and family members, including 25 phone calls to the MCO, we received approval to administer the medication in September 2021. We continue to negotiate on the patient's behalf because confusion continues regarding the patient's copay responsibility. Bottom Line: Attempts to white bag this patient's care resulted in a months-long disruption of care and the patient, family members and providers spent endless hours trying to resolve this issue.

Patient with Breast Cancer High Copayments: A breast cancer patient was being treated with a specific drug - fulphila. The patient received notice that the drug would have to be ordered through a specialty pharmacy. Before the pharmacy shipped the drug, the patient was required to pay an upfront cost of $4,100 per injection. This fee continued to be assessed until the patient reached a combined $11,000 specialty pharmacy and medical deductible. Not unlike many cancer patients, the disease and treatment disrupted the patient's life and created financial challenges. The specialty pharmacy did not offer the patient any assistance and the patient quickly exhausted her copay assistance benefit. To make matters worse, her out-of-pocket requirements were not being applied accurately. This has placed undue financial hardship on the patient, threatened the course of her treatment and her health and has caused her tremendous distress. Ascension Wisconsin, as her provider, is powerless to offer any additional support, such as charity care or drug discounts, as the medication order was placed by her insurance and their specialty provider, not the patient or provider. If the medications had been ordered through the hospital, we would have proactively offered assistance to the patient, and ensured her care was not disrupted as medication costs were being navigated.

Center for Neurological Disease Patient: A patient had a doctor-ordered increase in medication dosage for severe and chronic migraines that occurred as part of her neurological condition. Our staff tried three (3) times to get the medication order changed, but the specialty pharmacy could not find the order. In attempting to correct this, we reached out to numerous phone numbers, as the pharmacy did not have a consistent number for us to call. Our calls bounced from one area to another and answering representatives were not always able to see the notes from previous representatives within their same company, causing further confusion and wasted time. When the medication order was finally approved, there were shipping delays and the drug was received two days after it was scheduled. The patient's appointment needed to be

rescheduled three times and, due to the disruption in care, experienced medical concerns significant enough that the patient visited both an emergency room and urgent care to address symptoms that could have been avoided if treatment had been provided on a regular basis.

Koreen's law will prevent this unsafe and burdensome practice from further impacting patients' health and finances and allow them to focus on what is most important - their treatment and recovery. We respectfully request your support for SB 753.

Thank you for allowing us to testify today.

If you have any questions or if we can provide additional information, please contact Tracy Wymelenberg, Director of Government Relations & Advocacy iith Ascension at 414-465-3583 or at tracy.wymelenberg@ascenion.org.

Testimony before the Senate Committee on Insurance, Licensing and Forestry
2021 Senate Bill 753 – "Koreen's Law"
January 20, 2022

Wendy Biese, PharmD – System Pharmacy Director
ThedaCare, Inc.

Chairwoman Felzkowski and members of the Senate Committee on Insurance, Licensing and Forestry, thank you for the opportunity to testify before you today in support of Senate Bill 753. My name is Wendy Biese and I am the system pharmacy director for ThedaCare, Inc. My organization services a nine county region in northeast and central Wisconsin, including facilities in a small metropolitan area as well as five critical access facilities which serve as important health care safety nets in their respective rural communities.

You have heard some powerful testimony today about how patients and families across Wisconsin have been impacted by mandated white and brown bagging. Our patients at ThedaCare have not been exempt from the negative impacts of these practices, which I'm here to share with you today.

Patient Care Delays

- Patient care delays because of white/brown bagging are a regular occurrence at our facilities. We have seen up to a three week lag time between provider order and shipment of drug from the specialty pharmacy. The patient has no choice but to wait as the insurance won't allow a work around for care to be provided in a more timely and efficient manner.
- There is no connectivity between the specialty pharmacy and the receiving facility, with white-bagged drugs arriving after the patient appointment or being addressed to a wrong address and lost. The patient appointment is forced to be canceled at the last minute, often after the patient has arrived. Not only is this inconvenient for the patient who has planned other commitments around their appointment, but in some cases also has negative health consequences.

- I'd like to share a few specific patient examples:
    - An oncology patient was scheduled to receive her treatment. The patient care navigator received notification that the patient's insurance company is requiring the drug to be white bagged. The specialty pharmacy requires several weeks to process a prescription order, so the appointment was rescheduled. After processing the prescription, Optum Rx required the patient to authorize delivery. The call the patient received from Optum was automated, which the patient thought was spam, and hung up on before giving authorization. One of our pharmacists called Optum Rx a few days prior to the new appointment to confirm that the drug shipment would arrive, only to learn that Optum Rx was waiting for the patient to contact them to authorize delivery. The pharmacist then contacted the patient who did not know what white bagging is, that her insurance company was requiring her med to be white bagged, or who Optum Rx is or how to contact them. The patient appointment needed to be rescheduled yet a second time causing in total, a 6 week delay.

    - Another one of our oncology patients was receiving treatment at a non-ThedaCare institution. In the middle of his chemotherapy cycle, his insurance dictated that the patient had to change to having his medications white bagged. The institution he

initially was treating at does not allow white bagging due to the liability and safety concerns with accepting white bagged medications. The patient took it upon himself to call around to find a cancer care center that would allow white bagged medications. The patient was forced to re-establish care at a ThedaCare facility mid treatment, delaying his care as he attempted to navigate the system. This patient now drives over 30 minutes for treatment at ThedaCare rather than being able to treat a few minutes from his home.

- One of our patient's insurance company requires a monthly cancer medication be white bagged. The specialty pharmacy requires the patient to re-authorize the medication, reverify credit card information, and provide shipping details every month. The patient is only allowed to call after a certain day of the month to complete the tasks, with the additional caveat being that the specialty pharmacy only ships on Tuesdays. There is exactly a two-day window to complete the requirements or her medication will be delayed by a week. This is a lot for a patient to coordinate on top of having to deal with the other struggles of a cancer diagnosis and treatment.

The stress and delay of care that these patients are experiencing weighs heavily on them and their care teams. It was difficult to narrow down which recent ThedaCare patient stories to share with you today. I did not have enough time to even touch on other impacts we are seeing or the extra steps our ThedaCare team members are taking to try to prevent delays and make the process safer for our patients . I ask today that you put yourself in these patients' shoes because this could be you, your loved one, your child, your friend or your next door neighbor. You are not immune to this practice because more and more insurance companies are mandating white bagging.

I am here today to ask that you support Senate Bill 753. Thank you

WMC
Wisconsin's Chamber

TO: Members, Senate Committee on Insurance, Licensing and Forestry

FROM: Rachel Ver Velde, Director of Workforce, Education and Employment Policy

DATE: January 20, 2022

RE: Opposition to Senate Bill 753

Wisconsin Manufacturers & Commerce (WMC) appreciates the opportunity to comment on Senate Bill 753. WMC is concerned that this legislation was introduced and is opposed to its passage.

WMC is the largest general business association in Wisconsin, representing approximately 3,800 member companies of all sizes, and from every sector of the economy. Since 1911, our mission has been to make Wisconsin the most competitive state in the nation to do business. According to our most recent CEO survey, our members say that making health care more affordable is the best way that state government can help businesses in Wisconsin.

The high cost of health care has consistently been a top concern of WMC's membership over the years and that is for good reason. Wisconsin is an outlier when it comes to the cost of health care. In fact, a 2021 study by WalletHub found that Wisconsin is the 9th highest state for the cost of health care nationwide[1]. Often we hear that the cost of health care is high because our quality of health care is much better than other states. Unfortunately, that is not quite the case. The same WalletHub analysis shows Wisconsin has slipped to 13th for health care outcomes. That is down four spots from WalletHub's same analysis in 2018.

The good news is that it is possible to be a high quality, low cost state. For example, Rhode Island is the 4th lowest in cost and the 8th best in outcomes. Even our neighbor, Minnesota, is better than Wisconsin ranking 2nd lowest in cost and 9th best in outcomes. Wisconsin needs to keep its employer-based health insurance system and promote consumer-driven health care. The state legislature creating additional hurdles, as is done in SB 753, eliminates employers' ability to innovate and provide quality, low cost health care to their employees and their families.

SB 753 removes important tools that slow and sometimes even reduce health care costs for employers. The bill eliminates a process called white bagging that health insurers and employers have sometimes implemented to deliver clinically administered drugs directly to providers. This process allows payers to control the costs of these drugs since hospitals impose massive markups on these medications. A study by The Moran Company on behalf of The Pharmaceutical Research and Manufacturers of America shows that 83% of hospitals charge patients and insurers more than

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[1] https://wallethub.com/edu/states-with-best-health-care/23457

double their acquisition cost for medicines[2]. But, shockingly, the analysis is even worse when more closely examined. One-in-ten hospitals markup drugs 900% or more, with 320 hospitals marking up medicines over 1000%.

With this stark of numbers, it is easy to see why employers and health insurers have turned to other options, such as white bagging, to provide affordable clinician administered drugs to their employees and patients. If SB 753 would become law, there would be no tool to get hospitals to the table and negotiate the price of these drugs. And, as the data shows above, it is imperative that the hospitals are held accountable for their markups on prescription drugs. It is quite shocking that the legislature would consider giving hospitals a monopoly on these drugs and push other competition out of the market.

Employers currently are challenged to provide quality, affordable health care to their employees and their families. The trend of increasing hospital markups on medication is unsustainable. Nine-in-ten plan sponsors say high drug prices already jeopardize the affordability of employer-provided health coverage[3]. The legislature should be doing all it can promote innovation and price transparency in order to create more competition, not less.

WMC urges members of the Senate Committee on Insurance, Licensing and Forestry to oppose this interference in private contracts that will take away an important tool for employers throughout Wisconsin to contain the costs of healthcare, while creating a monopoly in the market for clinician-administered drugs.

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

[3] https://www.plansponsor.com/employers-remain-optimistic-health-benefits-despite-higher-projected-costs/

RWHC
Your partner. Your source.

TO: Senate Committee on Committee on Insurance, Licensing and Forestry
Senator Mary Felzkowski, Chair

FROM: Jeremy Levin, MHA,
Director of Advocacy

DATE: January 20, 2022

RE: SUPPORT Senate Bill 753—Protecting Patients from Mandated Insurance Practices

The Rural Wisconsin Health Cooperative (RWHC), owned and operated by forty-five rural community hospitals, thanks you for this opportunity to share our support on Senate Bill 753, which prohibits certain practices relating to insurance coverage of clinician-administered drugs. RWHC thanks the 80 lawmakers whom make up the strong bipartisan list of legislators who believe the insurance practices you've heard about earlier are causing harm and frustration to our rural patients and their communities.

Rural hospitals and clinics have dedicated staff that assist patients with accessing the care they need and helping decipher related coverage by insurance companies. This includes: assuring their provider is in-network, what prior authorizations are required, calculating deductibles/copays and identifying how ancillary services such as lab, x-ray and rehab therapies are accessed and the associated costs. Given that most rural facilities have more than 20 health plan contracts, this is a complex resource to establish for their patients. The purpose of health insurance companies should be to cover their rural recipients receiving the care they need close to home, not seeking ways to undermine the benefits of their health insurance coverage.

RWHC believes insurance companies unilaterally imposing requirements like white bagging and brown bagging increase safety concerns and ultimately drives patients away from their local care team they trust when they need them the most. Additionally, Health insurance seems to be copycat industry so it is likely that once one implements white bagging that other insurers will soon to follow, not to mention that white bagging is the tip of the iceberg as insurance companies restrict other services such as imaging, lab, certain surgeries, etc. all eroding availability of care at rural providers.

Rural hospitals are connected in with their communities, not only by the quality healthcare they provide, but as an integral member of the rural community's economy and daily life. Rural hospitals conduct a Community Health Needs Assessment every three years, where their communities are surveyed about the healthcare services that are desired and that community members value most. As health insurance companies seek to change care and services covered at rural hospitals, steering services outside that rural

community hospital they are fragmenting the rural health care safety net to a point where rural Wisconsin health care could see the closure of facilities that has plagued other areas of the country.

Thank you again for this opportunity to express our support for the Senate Bill 753. We encourage the Committee to act on the bill so that they might become law and more can be done to help maintain local healthcare in rural Wisconsin.

RWHC
Your partner. Your source.

TO: Senate Committee on Committee on Insurance, Licensing and Forestry
Senator Mary Felzkowski, Chair

FROM: Michael Ballinger
Director of Payer Contracting

DATE: January 20, 2022

RE: Support of "Koreen's Law" - Senate Bill 753

Chairwoman Felzkowski and Senate Committee members, thank you for the opportunity to testify before you today in support of Senate Bill 753.

My name is Michael Ballinger and I'm the Director of Payer Contracting with the Rural Wisconsin Health Cooperative. I have over 30 years of managed care contracting experience having worked directly on both the insurance and provider sides of the industry, and now at the Rural Wisconsin Health Cooperative. In my job at RWHC, I am responsible in helping our rural hospital members in not only negotiations with insurance companies, but also in helping them navigate the ever changing managed care landscape and related insurer policies.

The majority of insurance companies that have implemented white bagging/specialty drug programs have done so under the guise of policy or protocol changes, or as a designated network. Contrary to what some may led to believe, such changes have not typically been done as part of a proactive, good faith contract "negotiation", but rather have taken place by way of some sort of "notice" resulting from a change in payer policies, protocols or provider manuals.

These changes have generally not only taken place during the middle of the patients benefit plan year, but also during the middle of the insurance company - hospital contract term. It has been my experience that in the rare instance that an insurance company is willing to amend contract terms as a result of such changes, that there is little to no negotiation of terms, rather instead the hospitals, especially those that are rural, may at best get a take it or leave it offer – hardly a negotiation.

Besides such programs themselves being implemented mid plan year or mid-contract, I think it is also important to note that the list of drugs included under the respective payer polices are also subject to change at the payers' sole discretion once implemented, and result in yet another set of insurance rules and requirements for patients and hospitals need to try to keep apprised of. Knowing which drugs apply for which insurance company is a constantly moving target and requires significant administrative resources for hospitals to monitor, ultimately adding to administrative costs.

This is not a one and done change and while it may not impact a patient today, it could next month or the month after that as the list of included drugs continually changes.

Lastly, it is important to note that not only does every insurance company has its own list of included drugs, but they also use different specialty drug vendors and have different authorization requirements. There are currently at least 8 different vendors that various insurance companies are using to administer their respective specialty drug program. While some of these vendors represent more than one payer, the drug lists and administrative requirements usually vary by payer, or even by plan, which makes keeping track of it all daunting to say the least. The lack of commonality, unique requirements, and processes, makes it difficult for not only the hospitals, but also for the patients to understand and comply.

Thank you again for listening and ask that you please support Senate Bill 753 not only for the sake of patient care and access to care locally, but also for the sake of our hospitals, especially those trying to provide care in rural communities.

Designated specialty pharmacy network*

Published: Apr 1, 2021 - **Products & Programs** / Pharmacy

Beginning July 1, 2021, Anthem Blue Cross and Blue Shield (Anthem) is implementing a designated network for select specialty pharmacy medications administered in the outpatient hospital setting, **Designated SRx Network**. This applies to all Anthem commercial members and claims priced by Anthem for commercial BlueCard program members. This does not apply to Medicare Advantage, Medicaid, Medicare Supplement, or the Federal Employee Program.

Hospitals that are **not** in our Designated SRx Network will be required to acquire the select specialty pharmacy medications administered in the hospital outpatient setting through CVS Specialty Pharmacy. **For dates of service on or after July 1, 2021**, the prescribing provider for Anthem commercial members should continue to contact AIM Specialty Health or IngenioRx for prior authorization. During the authorization process, the prescribing provider will be notified of the requirement to utilize CVS Specialty as the dispensing provider for the specialty pharmacy medication when administered in the outpatient hospital setting. The failure to do so will result in claim denials and the member cannot be billed for these specialty medications. Hospitals may continue to submit a claim for administration of the specialty pharmacy medications in the outpatient hospital setting, which will be reimbursed at the current contracted rates.

If you wish to be included in the Designated SRx Network by agreeing to the terms/conditions, please contact your Anthem facility contract manager.

The list of specialty pharmacy medications subject to the above will be posted at anthem.com for reference and is subject to change. All specialty pharmacy prior authorization requirements will still apply and are the responsibility of the prescribing provider.

This will have no impact on how members obtain non-specialty pharmacy medications at retail pharmacies or by mail-order.

Designated specialty pharmacy network updates effective January 1, 2022*

Published: Oct 1, 2021 - **Products & Programs** / Pharmacy

**Material Adverse Change (MAC)*

As we previously communicated, Anthem Blue Cross and Blue Shield (Anthem)'s Designated Specialty Pharmacy Network requires providers who are not part of the Designated Specialty Pharmacy Network to acquire certain select specialty pharmacy medications administered in the hospital outpatient setting through CVS Specialty Pharmacy.

This update is to advise of the following changes:

Effective for dates of service on and after January 1, 2022, the following specialty pharmacy medications will be **added** to the Designated Medical Specialty Pharmacy drug list. Accordingly, hospitals that are not in the Designated Specialty Pharmacy Network will be required to acquire these specialty medications administered in the hospital outpatient setting from CVS Specialty Pharmacy.

HCPCS	Description	Brand Name
J1554	Injection, immune globulin (asceniv), 500 mg	Asceniv
J7204	Injection, factor viii, antihemophilic factor (recombinant), (esperoct), glycopegylated-exei, per iu	Esperoct
J7208	Injection, factor viii, (antihemophilic factor, recombinant), pegylated-aucl, (jivi), 1 i.u.	Jivi
J7212	Factor viia (antihemophilic factor, recombinant)-jncw (sevenfact), 1 microgram	Sevenfact
J9144	Injection, daratumumab, 10 mg and hyaluronidase-fihj	Darzalex Faspro

HDA
Healthcare Distribution Alliance

PATIENTS MOVE US.

January 13, 2022

Senator Mary Felzkowski,
Chair of the Committee
Room 415 South, State Capitol
PO Box 7882
Madison, WI 53708

Re: Healthcare Distribution Alliance (HDA) Statement on White Bagging – Support SB753

Dear Senator Felzkowski & Members of the Committee,

On behalf of the Healthcare Distribution Alliance (HDA), representing the nation's primary healthcare distributors, I am writing to encourage your support of Senate Bill (SB) 753. If successfully enacted, this legislation would ensure critical medications are available when the patient arrives for treatment based on their unique, real-time needs.

SB 753 would limit the ability of certain entities (Payers) to create restrictions relating to insurance coverage for and access to physician-administered drugs, most notably, the growing practice of "white bagging" which has the potential to disrupt patient care and is increasingly being required by insurers and pharmacy benefit managers (PBMs).

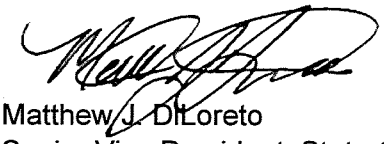
HDA's distributor members serve as the critical logistics provider within the healthcare supply chain, adding efficiency, security and keeping the healthcare system functioning every day. HDA members work 24 hours a day, 365 days a year to ensure approximately 10 million healthcare products per-day,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

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. Additionally, the practice of white bagging has the potential to increase 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. Any policies that prevent physicians from delivering timely access and safe administration of medically necessary drugs should be opposed. HDA respectfully asks that you support SB753. If you have any questions, please contact me at mdiloreto@hda.org.

Thank you,



Matthew J. DiLoreto
Senior Vice President, State Government Affairs & Alliance Development
Healthcare Distribution Alliance (HDA)

cc: Senate Committee on Insurance, Licensing & Forestry
Senator Rob Stafsholt
Senator John Jagler
Senator Lena C.Taylor
Senator Janis A. Ringhand

Froedtert | South

Testimony before the Senate Committee on Insurance, Licensing & Forestry
2021 Senate Bill 753
January 20, 2022

Thomas Kelley, JD, MBA, FACHE, FHFMA – Vice President & Chief Financial Officer
Brian Morton, PharmD, MBA – Senior Director of Pharmacy
Froedtert South, Inc.

Chairwoman Felzkowski, Ranking Member Taylor and members of the Senate Committee on Insurance, Licensing and Forestry, thank you for taking our testimony on Senate Bill 753, legislation protecting patients from insurance company practices that disrupt care when they need it most. On behalf of Froedtert South, which employs approximately 2,200 team members and has approximately 300 physicians and mid-level providers on its Medical Staff who provide exceptional and compassionate healthcare services to the community members who live in, and around, Kenosha County, we appreciate the opportunity to share with you our organization's concerns with these growing insurance company practices and ask for your support of Senate Bill 753.

From a background perspective, please know that Froedtert South is a comprehensive regional healthcare system that has served southeastern Wisconsin and northern Illinois communities for more than 100 years. Froedtert South provides services primarily through the Froedtert Kenosha Hospital, which is located in the City of Kenosha, and the Froedtert Pleasant Prairie Hospital, which is located in the Village of Pleasant Prairie, along with multiple clinics located throughout Kenosha County.

Early last year, Froedtert South received a disturbing letter from an insurance company with an ultimatum -- accept substantially reduced reimbursement for certain high-cost outpatient pharmaceuticals or the insurance company would unilaterally exclude Froedtert South's pharmacy for these certain high-cost outpatient pharmaceuticals from the insurance company's network effective July 2021. Froedtert South was shocked to receive this letter, particularly since Froedtert South had just concluded good faith negotiations for a multi-year renewal agreement with the same insurance company just a few short months earlier. Notably, during the good faith negotiations, the insurance company did not give any indication, notice, or warning that it was planning to send such an ultimatum. Recognizing Froedtert South had just completed good faith negotiations for a multi-year renewal agreement with the insurance company, Froedtert South did not agree to the insurance company's ultimatum.

On July 1, 2021, the Froedtert South pre-authorization team began receiving confusing information from the insurance company's pre-authorization intake team while attempting to pre-authorize certain high-cost outpatient pharmaceuticals for cancer patients. During some of these calls, Froedtert South was notified that while these outpatient pharmaceuticals were approved as medically appropriate, and while Froedtert South could administer the outpatient pharmaceutical, it could not administer its own inventory of pharmaceuticals to its patients because the Froedtert South pharmacy was out-of-network with the insurance company (despite contract language within our multi-year renewal agreement that provides that Froedtert South is, and shall, be in-network with the insurance company). Equally as concerning, our patients said that their insurance company did not pro-actively notify them of this unilateral decision to attempt to remove the Froedtert South pharmacy from their network for these outpatient pharmaceuticals.

6308 Eighth Avenue ■ Kenosha, WI 53143-5031 ■ (262) 656-2011

From July 1, 2021, through September 24, 2021, the insurance company inappropriately denied claims for twenty-two (22) patients, encompassing fifty-seven (57) unique outpatient pharmaceutical encounters for Froedtert South's most vulnerable patients, alleging that Froedtert South was no longer an in-network provider of these pharmaceuticals. Despite these bad faith denials, Froedtert South proceeded with clinically administering the outpatient pharmaceutical from the Froedtert South inventory to its patients to attempt to mitigate care delivery issues.

Had Froedtert South acquiesced to this insurance company's bad faith attempts to inappropriately deny these claims, our most vulnerable patients might have had their healthcare needs negatively impacted. Recognizably, many of these patients were going through life-saving medical treatments such as chemotherapy. Going through cancer treatment is stressful enough, the last thing they needed was for their insurance company to make it more difficult to get the potentially life-saving treatments.

Ultimately, after several correspondences with the insurance company's legal counsel, the insurance company acknowledged that our multi-year renewal agreement did not allow for their bad faith attempt to remove Froedtert South's pharmacy from their network and the insurance company has since resolved this issue for claims on a going-forward basis.

While we strongly encourage you to support Senate Bill 753, we must also consider what a future might look like if Senate Bill 753 doesn't ultimately become a law. In that scenario, we foresee the potential of significant patient issues occurring including, but not limited to, the following:

- Significant patient safety concerns including delays in treatment, wrong drugs being supplied, patient confusion, and difficulties in coordinating care.

- Access barriers and consumer protection issues resulting from confusion for patients and their healthcare providers because of fragmentation of care (e.g., which departments of a healthcare system may be deemed as in-network by the insurance company versus which departments of a healthcare system may be deemed by the insurance company to be out-of-network).

- Challenges for patients resulting from hospitals and clinics being unable to manage this complex and confusing process safely, leading to the possibility that some healthcare providers may no longer administer these white bagged pharmaceuticals, resulting in a decrease in community access to unique and vitally important outpatient pharmaceuticals.

In addition to the above referenced patient issues, there are also potentially ramifications to the healthcare system, healthcare providers and hospital-based licensed pharmacists.

For instance, pharmaceuticals that are required to be sourced outside of the normal supply chain, via a payor-mandated distribution channel, eliminates a healthcare system's quality control process as defined, in part, by the Drug Supply Chain Security Act ("DSCSA"), as enacted by Congress on November 27, 2013. The DSCSA was created to strengthen the security of the drug distribution supply chain by adding controls such as a national pharmaceutical track-and-trace system and establishing national standards for licensing of prescription drug wholesale distributors and third-party logistics providers.

If white bagging is required for clinician-administered pharmaceutical to be dispensed exclusively, via payor-mandated distribution channels, healthcare providers, and hospital-based licensed pharmacists would lose control over the preparation, handling, storage, and delivery of that pharmaceutical. This

would eliminate their ability to assure the quality of the pharmaceutical prescribed, threatening to compromise healthcare providers' well-established practices intended to ensure patient safety.

Additionally, white bagging would negatively impact a hospital-based pharmacists' ability to validate medication integrity and maintain oversight of storage and handling. Further, by sidestepping well-established supply chain procedures, white bagging disrupts efforts to maintain adherence with protocols designed to ensure patient safety, quality, and continuity of care. In other words, the hospital-based licensed pharmacists would not be able to guarantee the integrity of the pharmaceuticals, which puts our pharmacist's licenses at risk and ultimately places the patients at risk.

Furthermore, white bagging results in care delivery problems, which impacts a healthcare system's workforce – during a time when hospitals are having substantial staffing challenges resulting from the protracted COVID-19 pandemic – requiring additional staff to manage this complex process, additional storage space and equipment, and logistics for managing a segregated third-party pharmaceutical inventory.

From a logistics perspective, as you might imagine, hospitals have multiple points of entry and, unfortunately, the very complex white bagging process does not have a well-developed or well-established delivery model to a healthcare provider. Having said that, temperature-sensitive pharmaceuticals have been delivered to all areas of the hospitals such as loading docks, outpatient areas, physician offices and other areas at all times of the day, which may have exposed the product to extreme temperatures resulting in significant product integrity concerns as well as substantial pharmaceutical security issues.

In support of these important patient and provider concerns, Vizient, Inc. recently released a survey analysis (https://newsroom.vizientinc.com/new-vizient-data-estimates-us-hospitals-spend-310-million-annually-on-management-whitebrown-bagging-requirements-for-specialty-pharmaceuticals.htm?pressrelease) in August 2021, which estimates U.S. hospitals are spending $310 million annually to manage the additional clinical, operational, logistical, and patient care work associated with white bagging and brown bagging requirements. According to the article, the survey included responses from 260 hospitals obtained between March and April 2021 and shows that due to these payor-imposed mandates, hospitals have already spent an estimated $114 million on additional staff to manage the excess coordination associated with white bagging. *However, the report also added that the full cost of the practices is not yet known, since most hospitals have not yet started tracking the costs.*

Furthermore, according to the survey analysis, "White and brown bagging is causing staffing resource challenges and increased expense for hospitals at a time when COVID-19 has already caused significant hardships," said Dan Kistner, PharmD, group senior vice president, Pharmacy Solutions for Vizient. "The reality is that this may simply be the tip of the iceberg, as most hospitals have not taken the steps to quantify the financial impact white and brown-bagging have had on their institutions," Kistner added. "As hospitals navigate this complex issue, they must develop a strategy to evaluate the extent of impact to their organization and their patients, educate their financial and managed care leaders, and advocate for legislative reform for themselves and their patients."

Moreover, the survey analysis noted that these payor-mandated changes to dispensing policies complicate access and creates delivery and dispensing delays impacting speed to therapy for patients, possibly resulting in negative outcomes and more financial burdens.

Additional key findings from the survey analysis include the following:

- 92% of respondents experienced problems with the medication received through white/brown bagging including issues such as wrong drug, damaged product, dose not arriving in time for administration, and dose no longer appropriate due to patient's therapy changes.

- 95% of respondents experienced operational and safety issues associated with white/brown bagging. The issues encountered included: separate inventory management system, delivery location/security disruptions and lack of space to hold medication (e.g., refrigeration).

Ultimately, healthcare is supposed to be about the patient and about providing the right care, in the right setting and at the right time. Unfortunately, in August 2021, these white bagging requirements caused this set of aims to fail for a Froedtert South patient.

In August 2021, one of our Froedtert South Hematologists ordered a coagulation factor medication to treat a patient for hematomas and pain in their hips and legs. During the prior authorization process, Froedtert South learned of an insurance-mandated requirement forbidding the pharmaceutical from being dispensed by the Froedtert South pharmacy and, instead, requiring the use of an external specialty pharmacy. In order to treat the patient, Froedtert South attempted to follow the insurance company's direction to use an external specialty pharmacy; however, the clinician-administered pharmaceutical would not be delivered to Froedtert South for 10 days due, in part, to a lengthy shipment process. The patient experienced a significant first line treatment delay as a direct result of this payor-mandated white bagging process.

Due to the payor-mandated white bagging process delays caused, in part, by the lengthy shipment time, Froedtert South was not able to timely provide this patient with the white bagged pharmaceutical and the patient deteriorated to the point where the Hematologist believed an inpatient admission was necessary to emergently administer the coagulation factor medication. This resulted in a 5-day hospitalization, in the Intensive Care Unit, during which the patient received 5 consecutive days of the coagulation factor medication.

These actions taken by insurance companies described above have real and potentially life-threatening consequences for patients when they are most vulnerable. Unfortunately, this trend has only just begun and will become much, much worse without this legislation becoming law. By supporting Senate Bill 753, you will stop insurance companies from unilaterally implementing policies that fragment care to the detriment of patients to whom we serve. We ask for your support of this critical legislation as we work to maintain the highest quality care for the patients we serve.

We welcome Committee members to contact us directly at tom.kelley@froedtertsouth.com or brian.morton@froedtertsouth.com with any questions regarding the information we provided.

pharmacists advancing healthcare®

Date: January 14, 2022

To: Members of the Senate Committee on Insurance, Licensing and Forestry

From: ASHP (The American Society of Health-system Pharmacists)

Subject: Support for Senate Bill 753 (Koreen's Law)

Members of the Committee,

ASHP is the collective voice of pharmacists who serve as patient care providers in hospitals, health systems, ambulatory clinics, and other healthcare settings spanning the full spectrum of medication use. The organization's more than 60,000 members include pharmacists, student pharmacists, and pharmacy technicians. For 80 years, ASHP has been at the forefront of efforts to improve medication use and enhance patient safety. We appreciate the opportunity to provide comments on Senate Bill 753 and ASHP supports the Patients First Wisconsin Coalition efforts to address the threat to health care quality, safety and affordability posed by insurance companies use of the practice described as "white bagging".

ASHP stands opposed to payer-mandated white bagging models that jeopardize optimal, safe, and effective medication use. Payer-mandated distribution models that require clinician-administered drugs to be dispensed exclusively via third-party specialty pharmacies threaten to compromise provider efforts to ensure patient safety and negatively impact pharmacists' ability to validate medication integrity and maintain oversight of storage and handling.

ASHP believes that patients and providers must have choice in obtaining clinician-administered drugs, and that payers should not be permitted to unilaterally require methods of distribution that disrupt the patient experience and impair the provider's ability to provide optimal patient care.

Payer-mandated white bagging occurs when a health insurer or pharmacy benefit manager requires clinician-administered drugs to be shipped from a plan-designated third-party pharmacy to the hospital or clinic where the patient receives the drug. A variation of this is payer-mandated brown bagging, which introduces additional risks and safety concerns, and occurs when a health insurer requires a pharmacy to dispense a clinician-administered drug directly to an enrollee, policyholder, or insured or agent of the insured with the intention that the enrollee, policyholder, or insured or agent of the insured will transport the medication to a health care provider for administration. These insurers mandated practices pose a threat to health care quality, safety and affordability to patients and providers.

White bagging deviates from established safe forms of drug acquisition

Traditionally, health care providers purchased clinician-administered drugs directly from wholesalers and kept bulk drug stock stored in the pharmacy, enabling them to prepare medications for administration in advance of scheduled appointments. Payer-mandated white bagging policies prohibit health care providers from directly purchasing these drugs, and instead require a separate mail-order pharmacy to provide a patient-specific dose

of the medication to the hospital or clinic that administers the drug. These drugs are not typically supplied in ready-to-administer dosage forms and often require additional sterile compounding and manipulation by licensed health care professionals before they can be safely administered to a patient. Additionally, requiring the use of these processes is inconsistent with established state and federal regulations on safe handling, transport, storage, and tracking of medications.

Payer-mandated white bagging hurts the patient experience

Introducing additional unnecessary third-party pharmacies into the drug delivery process requires the patient to coordinate separately with two different entities to receive care. Patients have to pay separate co-pays to both the pharmacy that dispenses the drug and the provider that administers the drug. Shipping and processing delays resulting from the fractured care delivery model can result in delayed treatment, unnecessary additional trips to the hospital or clinic, and rescheduled appointments. Payer-mandated white bagging also diminishes the provider's ability to provide prompt "just in time" treatments that could prevent unnecessary hospital admissions.

Payer-mandated white bagging makes health care delivery less efficient and increases overall costs

By prohibiting hospitals and clinics from direct purchasing drugs, white bagging stretches supply chains by introducing an additional unnecessary shipping step. Instead of going directly from a wholesaler to the point of administration, medications are routed from the wholesaler to a third-party pharmacy, who then ships the medication to the point of administration. Further, white bagged drugs are supplied as individual patient-specific packages that may be delivered by any common carrier. Instead of receiving a singular planned and anticipated daily bulk delivery from a drug wholesaler, administering facilities must navigate receipt and processing of a separate parcel for each individual patient. Particularly at larger health systems, the variation in delivery channels often results in drugs being delivered to an incorrect location, causing further delays in patient care and increasing the potential for drugs to spoil in an inappropriate location.

White and brown bagging of drugs also increases drug waste. Since white and brown bagged drugs are "dispensed" by the third-party pharmacy that ships the medications, they are legally personal property of the patient. As such, the drug must be stored separate from other drug stock in segregated inventory and any unused portion of the drug product cannot be re-appropriated for use by other patients and must be discarded. Similarly, pharmacy practice laws stipulate that white bagged medications that are never administered to a patient cannot be returned to the pharmacy that shipped them and it is unclear how providers are to lawfully dispose of these drugs, since they never assume formal ownership them.

Conclusion

Senate Bill 753 (Koreen's Law) protects and empowers patients and providers to make choices meant to serve the patient's best interest. ASHP supports the Patients First Wisconsin Coalition efforts to address the threat to health care quality, safety and affordability posed by insurance companies use of the practice described as "white bagging". ASHP as a partner of the Patients First Wisconsin Coalition strongly encourages the passage of this important legislation for the citizens of Wisconsin.

If you have any additional questions, please contact Kyle Robb (krobb@ashp.org). Thank you!

PRISM HEALTH GROUP

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January 20th, 2022

The Honorable Mary Felzkowski, Chair & Members
Senate Committee on Insurance, Licensing & Forestry
P.O. Box 7882
Madison, WI 53707-7882

The Honorable Joe Sanfelippo, Chair and Members
Assembly Committee on Health
PO Box 8953
Madison, WI 53708

To Whom It May Concern:

Chairwoman Felzkowski and Chairman Sanfelippo, and distinguished members of the Senate Insurance and Assembly Health Committees, my name is Ryan Rice, Principal and Practice Lead of The Prism Health Group (Prism). Headquartered in Salt Lake City, Utah, Prism is an independent pharmacy consulting firm that provides a wide array of pharmacy specific consulting services and industry analytics solutions that lowers cost of care, improves care delivery, and enhances the quality of our client partners' respective pharmacy programs.

Most notably, as a truly independent pharmacy consulting firm, Prism provides pharmacy thought leadership to more than eighty (80) client partners across the country, twenty-five (25) of which represent client partners across the state of Wisconsin. Prism proudly serves some of Wisconsin's largest employers, representing self-funded employers of several thousand employees, large hospital system providers, rural small businesses, and healthcare professionals from across the Badger State.

Above all, we are here today to provide our industry expertise and insight specific to how we believe AB 718 / SB 753 will impact all parties, i.e., providers, employers, and patients if passed into law. Although we are in opposition to AB 718 / SB 753, our insights are meant to provide important context to those who oppose and those that support AB 718 / SB 753. Our ultimate aim is to provide valued context into the broader impacts this bill will have for all Wisconsin healthcare consumers if passed into law.

Over the past several years, rising healthcare costs have caused employers, health systems, and law makers to think critically about seeking new ways to responsibly manage increasing healthcare costs, while also ensuring a cohesive continuum of patient access and high degree of quality care.

New advances in medical technology and drug treatment regimens are surely providing new hope for those struck with complex and historically devastating health diagnosis, which represents an incredible time in history to be witnessing these significant leaps forward.

That said, these leaps and bounds in treatment innovation also come with incredible cost to consumers at the pharmacy counter, the employer sponsoring the plan, as well as to providers that must administer these complex drug regimens.

Recent analysis shows that pharmacy represents the fastest growing segment of healthcare expenditure for insurance carriers, self-funded employers, and consumers standing at the pharmacy counter. On average, thirty-three cents ($0.33) of every American healthcare dollar spent today is representative of pharmacy related cost expenditures.

Upon further analysis of detailed pharmacy claims utilization data, less than one percent (1%) of a given employer's plan participant population represents more than fifty percent (50%) of the overall drug costs, making it increasingly challenging to provide a wealthy, yet balanced healthcare benefit to employees.

What's more, the pipeline of newly launched specialty medications that have already received FDA approval, or are in the process of being approved, all target treating highly complex diseases. The average cost of these medications has risen so drastically in the past five (5) years that many self-funded employers are facing the difficult decision to not extend coverage for these important treatments.

The reason we believe these details are critical for consideration in conjunction with the Wisconsin Legislature's path forward in voting on AB 718 / SB 753 is because of the inherent downstream impacts the bill will have in the healthcare ecosystem if passed.

Perception & Reality

Most vocal opponents to 'white/brown bagging' or alternative sourcing of pharmacy products within the provider infrastructure often make broad generalizations suggesting the program and process are terminally flawed. Opponents contend the program frequently results in extreme delays in treatment, requires distant pharmacies to ship medications, infers frequent incorrect dosing occurs, questions the efficacy and safety of fulfilled medications through this channel, and ultimately subverts physician and care team treatment initiatives.

What is often not said is that in most instances the non-affiliated pharmacies owned by drug wholesalers, pharmacy benefit managers, and affiliated insurance carriers, providing these medications via drop-ship are the same pharmacies that also provide other highly complex, specialty medications to members across the

country. In many cases, 'white/brown-bagging' often provides increased access to even more complex therapy medications than on-premises hospital and out-patient pharmacies, all while having the ability to ship medications overnight.

Said differently, the argument that these non-affiliated pharmacies owned by drug wholesalers, pharmacy benefit managers, affiliated insurance carriers, providing these medications via drop-ship are somehow less than qualified to dispense these medications is untrue. In fact, many of the providers opposing this bill source medications from the same locations that insurance carriers, PBM's, and employers source specialty medications.

It's important to note that hospitals, out-patient facilities, long term care providers, etc., all source most, if not all of these complex therapy medications from the exact same place that insurers, pharmacy benefit managers, and independent specialty pharmacies also acquire from. The fact that such a difference in price exists is justification to ask questions that reasonably scrutinize the supply chain.

Why should anyone pay double, triple, or even more for the same medication, simply because it was acquired and administered in a different setting. It's reasonable to assume that differences in administration of the drug results in a different cost, yet there is no justification for any entity to deliberately mark-up the price of a given good, acquired via the same source as a competing entity. It is these kinds of differentials that are cause for serious concerns should AB 718 / SB 753 pass as written.

While we agree that some classes of medications, due to varying factors of complexity, product sensitivity, and safety, may not be appropriate to source through white-bagging, many other medications absolutely meet the criteria to be sourced through alternative channels that represent potential cost savings and cohesiveness with the patient's insurance coverage.

Said a different way, under no circumstance is our recommendation to circumvent the provider, physician and care team to capture potential cost savings through sourcing medications via alternative pathways. Rather, instead of making a unilateral determination to prohibit the practice of white/brown bagging medications, we instead advise creating reasonable accommodations that keep the patient's best interests at the center of focus, while also encouraging innovative ways to sourcing medications that will achieve cost savings. This approach is possible, and is currently in operation today with one of Wisconsin's largest and most notable employers.

An Alternative Path Forward

One of Prism's largest Wisconsin based self-funded employer client partners chose to implement a new and innovative drug sourcing program in collaboration with Prism, their Pharmacy Benefit Manager (PBM), and their Third-Party Administrator. The program was designed to provide alternative access to specialty medications and complex therapy prescriptions through the employer's prescription benefit manager and their respective specialty pharmacy versus the medical benefit and provider pharmacy.

The purpose of the program was to access known deeper discounts on high-cost specialty pharmacy and complex care products that would have otherwise been sourced and administered in the hospital and/or outpatient setting for an incrementally higher cost.

In creation of Phase One of the solution, the targeted group of professionals included in the development of the solution comprised of Chief Medical Officers, Nurse Case Managers, Pharmacists, and various other industry experts, all of which came together to design a path forward that addressed this specific need.

In review of medical claims data, more specifically known as J-Codes, that processed through the medical benefit, the parties performed an analysis to determine which medications could be reasonably added to the pharmacy benefit instead of the medical benefit. Furthermore, the team also identified specific medications that represented structured administration criteria, as well as medications that could represent potential challenges for the member and the care team if sourced outside of the hospital setting. The reason this step was critically important was to avoid disrupting members with particularly challenging therapy treatments, i.e., oncology / cancer, antipsychotic, etc., which could risk health and safety if disrupted.

Said differently, the program deliberately identified products and patients that fit the ideal criteria for such a program to be implemented. The program would create work flows that required the provider to source these specific medications through the process of 'white/brown bagging' and without distributing the member's care. The team then weighed the cost savings potential with the work effort to create the program and the potential negative impacts of the program on the patient.

Phase One of the program required the member to adhere to any applicable utilization management (UM) criteria specific to the drug as outlined within the prescription benefit, i.e., prior authorization, step therapy, etc.

Then, assuming the patient went through the appropriate utilization management criteria required by the plan, the provider and member then coordinated delivery of the medication with the employer's delegated PBM and the patient's care team to facilitate the white/brown-bagging and delivery of the prescription.

As it stands today, Phase One of the program offers dual coverage of the medication under the medical and pharmacy plan, meaning if the provider is unwilling to accept 'white/brown-bagging' the provider can obtain the prescription through the traditional means of 'buy-and-bill' via the medical benefit, presenting zero disruption to the current care path.

Future phases aim to respectfully remove the dual coverage and require the provider to 'white/brown-bag' the prescription according to the benefit plan. The phased approach was completed with the goal of introducing the concept to the providers and member so that they may have the appropriate time to adjust to the idea and workflow of receiving their specific medication through the delegated PBM Specialty Pharmacy as outlined in the employer's plan document.

Above all, this solution was not created in a vacuum, rather it takes into account all aspects of the member's healthcare journey. A representation of the level of due diligence and thoughtful consideration is directly

reflected by the list of eligible drugs selected for the initial Phase One Prescription Drug List. The development team was very specific in selecting medications that first and foremost would not adversely affect the member's care continuum or cause delay in treatment.

Rather, the products selected were those that are frequently administered as outpatient or at-home medications. For example, while some competing solutions launched within the industry were positioned to include oncology medications as well as other similarly complex therapies, this solution purposefully did not affect this group of medications and patients for fear of adverse effects to the patient.

Program curators routinely meet to discuss the program structure to ensure continued success, all while balancing the member's care path, first and foremost.

In all, the employer that implemented this program stands to save significant dollars by sourcing these highly selective products through their PBM and respective Specialty Pharmacy. The program has helped to subsidize other valued programs and initiatives by the employer, such as zero-dollar insulin for all diabetics on the plan.

Implications to Cost

Specific to cost, AB 718 / SB 753 represents a few different challenges that impact both the provider as well as the payor:

Erosion of Market Competitiveness

Provisions within the proposed legislation that would eliminate an employer's ability to competitively source specific medications through their delegated insurance provider, third-party administrator, and/or pharmacy benefit manager (PBM), ultimately creating a competitiveness vacuum, allowing providers to subjectively alter pricing at their discretion.

Several Wisconsin employers that have implemented similar dynamic and innovative solutions to effectively source medications through qualified networks of specialty pharmacies, out-patient facilities, and drug wholesalers would be precluded from acquiring these medications via alternative price competitive channels, which often are bought at significant discount over the provider's inflated pricing.

If AB 718 / SB 753 is passed into law, this competitive price protection for consumers would be eroded, ultimately creating a monopolistic pricing landscape where consistently increasing profit margins on the acquisition of medications becomes commonplace.

Misaligned Provider Incentives

Another important, yet lesser-known cost implication that would result should AB 718 / SB 753 be passed into law is directly attributed to the 340B Federal Drug Subsidy Pricing Program that many Wisconsin hospitals and providers currently benefit from as Covered Entities under 340B.

At a high-level, the Federal Government provides access to highly subsidized drug pricing to delegated Covered Entities and Contract Pharmacies that qualify under the Federal Government's Health Resources and Services Administration (HRSA). The intent of the program is to allow Covered Entities to reach eligible patients and provide comprehensive pharmacy products and services. Maintaining services and lowering medication costs for patients is consistent with the purpose of the program, which is named for the section authorizing it in the Public Health Service Act.

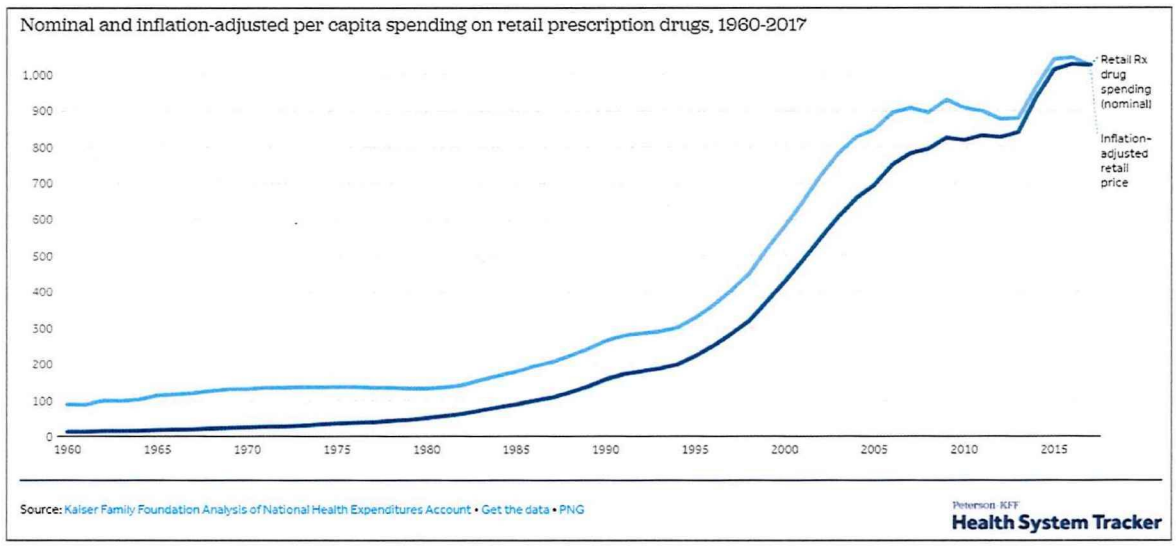
Several medications that AB 718 / SB 753 would impact are also eligible for 340B pricing. The 340B program also allows payors and Covered Entities to purchase the eligible drugs for literal pennies on the dollar, yet resell the drug to patients that have traditional insurance coverage through a carrier or through their employer at full retail value. The net result is a windfall of added revenue to the Covered Entity and Contract Pharmacy, all while not having to pass the lower cost and savings achieved through the 340B program to the patient, employer, or insurer.

The Moran Company produced a report for The Pharmaceutical Research and Manufacturers of America showing that approximately eighty-three percent (83%) of hospitals charge patients and payers more than double the acquisition cost for medications, in addition to a number of subjective administration fees. Many providers often site justification for extreme markups being a result of having to subsidize the lower received reimbursements from a portion of their patients being public payors such as Medicare and Medicaid. The issue with this mindset is the overarching assumption that a self-funded employer has the same capital as the federal government or national insurance carriers, and can afford to pay for incurred costs as they arise. The reality is, the typical self-funded employer group doesn't have the same risk tolerance that government entities and national carriers possess, and they cannot keep up with the rapid rate of increased costs.

There are several different Wisconsin providers that are currently qualified as Covered Entities under the 340B Drug Subsidy program, and make highly discounted medications available to patients across the state through successful deployment of the program. If AB 718 / SB 753 passes into law, providers, Covered Entities, and Contract Pharmacies will greatly benefit from the increased capture of eligible drugs within their facilities, all while not having to share the deep discounts and cost savings with the consumer and/or insurance provider / employer downstream.

In addition to being mindful of the dynamics of market competitiveness and the nuances of lesser-known benefits to providers, the greater, more pressing matter at hand remains the significant risk posed to those who cannot afford their healthcare due to the complexity of the American healthcare system and the incredibly high cost of care.

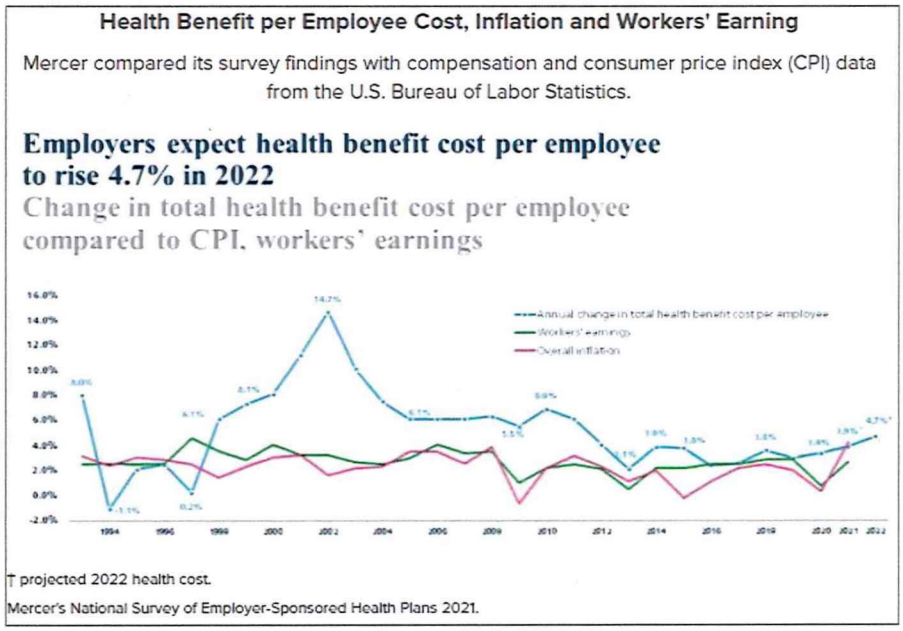
A report published by The Peterson Center on Healthcare and Kaiser Family Foundation (KFF), a partnership that monitors the United States healthcare system quality and cost, showcases an analysis of National Health Expenditures Account data reporting that on a per capita basis, inflation-adjusted retail prescription drug spending in the U.S. increased from ninety dollars ($90) in 1960 to well over a thousand dollars ($1,025) in 2017.



These findings are critically important, as it validates an increase in drug cost not only effects employers bottom line, but also has an impact on patient care with one in four (1:4) stating they have a difficult time affording their medication.

There is no one culprit or benefactor of rising drug costs, rather drug cost is divided among many hands.

Researchers from Washington University School of Medicine calculate that for every one-hundred dollars ($100) spent on medicine, manufacturers yield fifteen dollars ($15), wholesalers make thirty cents ($0.30), pharmacies make three dollars ($3), insurers make three dollars ($3) and pharmacy benefit managers make two dollars ($2). The rest is eaten by production costs and ancillary cost line items. Neither



member nor employers have been immune to rising drug costs.

Employers are faced with a health benefit cost per employee rise of nearly five percent (5%).

Out of necessity to balance plan cost and drug spend, while yet aiming to provide affordable benefits to their members, employers have been forced to seek innovative solutions to a complex cost ecosystem.

Some employer groups have introduced new ideas such as excluding specialty drugs, medical tourism, and exclusive coverage of generic medications. These solutions introduce sometimes inadequate and unreliable paths to mitigating increasing drug costs and plan spend.

Above all, as it relates to the impact to drug pricing and the cost to the consumer, we fundamentally believe AB 718 / SB 753 will significantly erode any semblance of price competitiveness as well as market competition for purchasers of healthcare goods and services. We believe this bill will embolden providers with a unilateral safe-space to dictate drug pricing, and there is little to no assurance that costs for critically important medications will remain competitive and accessible.

Most importantly, it's all too common that we hear narratives that would support the notion that the real enemy is the insurance company and/or payor. The common misconception in this circumstance is that the proverbial 'insurance company' for many Wisconsin citizens is actually their employer. The small business that elected to take control of their healthcare spend is not the same as the well-known PBM or national insurance carrier.

If AB 718 / SB 753 is passed into law, these prohibitions on employers and self-funded plan sponsors seeking reasonably safe and effective drug sourcing practices for high-cost medications will drive drug costs to incredible heights, while also eliminating dynamic options to provide high quality health coverage to employees and their families.

Said differently, although some tenants of AB 718 / SB 753 represent reasonable steps in refining the payor / provider relationship, other components of the bill will absolutely increase the cost of care to employers, employees and dependents.

Conclusion

In conclusion, Prism does not oppose all aspects of AB 718/SB 753, and instead would recommend the Health committee strongly consider the significant potential impacts to market competitiveness, price governance, and patient access to high quality healthcare options by way of innovative care delivery solutions if AB 718/SB 753 is passed. We also ask the Committee consider the ways in which some Wisconsin employers are already taking the initiative to successfully deploy innovative programs to lower cost and improve care.

In a time and climate where healthcare is constantly becoming more complex, consumers, employers, and providers must find amicable pathways to seek common ground and reasonable compromise. The pitch of healthcare costs continues to climb, and the healthcare system remains a difficult landscape to navigate.

Unless meaningful compromise between all parties is achieved, Wisconsin employers will continue to be faced with having to further dilute the value of their healthcare benefits to their employees and their families. All the while, Wisconsin citizens will continue standing at the pharmacy counter, growing more and more frustrated with broken, complex, and unaffordable options.

We believe a compromise is possible where payor and provider are willing to seek common ground, ensuring those we mutually serve won't suffer the pains of a historically broken system.

Respectfully,

Ryan T. Rice
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END

COMMON GROUND

HEALTHCARE COOPERATIVE

Written Testimony Opposing Senate Bill 753 Relating to Clinician-Administered Medications

Senate Committee on Insurance, Licensing and Forestry
January 20, 2022

Chairwoman Felzkowski and members of the committee, we appreciate the opportunity to submit written testimony regarding Senate Bill 753, which would require health plans to purchase clinician-administered specialty medications from hospital pharmacies. The legislation would also put constraints on medical management tools used by plans to help enrollees understand and realize cost-savings opportunities that could result from receiving medications in non-hospital settings.

Common Ground Healthcare Cooperative (CGHC) is Wisconsin's largest individual market insurer. As such, our membership consists mainly of the self-employed, those working in jobs that do not offer employer-sponsored health insurance and many early retirees. That means our members do not have other resources to help them navigate health care from a financial perspective, and that very important job falls to us, their cooperative.

CGHC is also nonprofit and member-governed, so we are not motivated to make more money. Our prices are based on how much we believe we will pay for health care, and any money we might make in a good year is returned to our members. Since 2019, CGHC has returned nearly $105 million in premium rebates to its members. The more we are successful in controlling costs by paying reasonable prices for care and ensuring the right care is delivered at the right time, the more money we can return to our members in future years.

Why We Oppose SB 753

Only a small percentage of our enrollees will need the very expensive specialty medications subject to this legislation, but these drugs make up a much larger percentage of our pharmacy spend. Generally speaking, CGHC does not engage in the practice of white-bagging as we have heard it described by proponents, although we do work with our members to help them receive clinician-administered drugs in a home-setting or in a doctor's office when it is safe and appropriate to do so. Not only does this save our members considerable money, but it is also the preferred site of care for many people and is frankly safer for our members than going to a hospital.

The language included in SB 753 is concerning in its breadth and scope. The definitions and prohibitions included in the bill do not seem to match up with the bill's stated intent. As the bill is written, it would seem to apply to nearly any medication that could be administered by a

clinician which could hamper our ability to serve our members with home or near-clinic setting alternatives. And, given the rapid increase in the number and price of clinician-administered drugs, this definition will have far-reaching implications for years to come on medications and delivery methods that will almost certainly evolve and improve over time.

Equally concerning is how this bill would impact our members who do not need clinician-administered drugs. The bill explicitly states: *"Any health benefit plan design that prevents participating providers from receiving reimbursement for a covered clinician-administered drug and any related service at an applicable rate as specified in the contract is prohibited under this subdivision."*

We can guarantee that the "applicable rates specified in the contract" will go up exponentially if the legislature effectively bars health plans from obtaining the drugs from anyplace other than hospitals. Based on this language and other provisions of the bill, it seems clear that this bill aims to protect hospital markups rather than patients, and that is something we take great issue with at the same time some of our members are being sent to collections for hospital bills they cannot afford. Hospital charges need to go down, not up, for the sake of consumers, employers and taxpayers that pay for the health care that is delivered in Wisconsin.

Conclusion

In closing, we'd like to point out that legislation is a one-size-fits-all approach that does not afford health plans the ability to work with clinicians and members on a case-by-case basis to determine what is best for patients from both a clinical and financial perspective. Despite the rhetoric surrounding this bill, the vast majority of health plans serving our state's resident are just as concerned about patient safety as health care providers are and have a long history of working with providers outside of legislation to address cost, quality, and patient safety concerns.

We urge you to protect our members, your constituents and insurance consumers in general and reject AB 753 and ideas like it that will add more costs to our health care system. If you have any questions, please do not hesitate to contact Melissa Duffy by email at mduffy@dcstrategies.org or by phone at (608) 334-0624.

PCMA

Date: January 20, 2022

To: Members of the Senate Committee on Insurance, Licensing and Forestry

From: Heather Cascone, Assistant Vice President, State Affairs for the Pharmaceutical Care Management Association (PCMA)

RE: Senate Bill 753 – White Bagging -- Oppose

Good Morning Chairwoman Felzkowski and members of the Senate Committee on Insurance, Licensing and Forestry. Thank you for the opportunity to provide written testimony to Senate Bill 753, a bill which would prohibit plans from the specialty drug delivery practice known as white bagging.

The Pharmaceutical Care Management Association (PCMA) respectfully submits the following comments for consideration in opposition to SB 753. PCMA is the national trade association representing America's pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 270 million Americans with health coverage provided through employers, health insurance plans, labor unions, Medicaid Medicare, Federal Employees Health Benefit Programs, and other public programs.

Preserving Payor Choices

PBMs and their health plan and employer clients use specialty pharmacies to deliver high quality, accessible pharmacy services while promoting product affordability. Flexibility to continue contracting with these select pharmacies is the key to ensuring access and promoting affordability in Wisconsin. When an employer or health plan decides to contract with a PBM to administer their pharmacy benefit, they maintain authority over the terms and benefit plan design, including how drugs should be obtained by or delivered to beneficiaries. The employer or plan— not the PBM— makes decisions regarding cost-sharing requirements, formularies, and networks, including the use of mail delivery of a drug to a patient or provider.

Shipping Safeguards for Drugs Requiring Special Handling

While the vast majority of shipped prescriptions do not require special handling or packaging, for those that do, mail-service pharmacies use U.S. Pharmacopeia guidelines to determine handling needs and leverage proprietary software to map out the ideal packaging journey, which accounts for the acceptable temperature range, forecasted weather conditions, and destination temperatures. Proprietary software is used by PBMs to map out a delivery path for those prescriptions that must stay within a specific temperature range. Such software accounts for the acceptable temperature range for each prescription, forecasted weather conditions, and destination temperatures. Based on this information, the appropriate shipping time frame and packaging are determined specific to that prescription. For example, a mail-service pharmacy may package prescription drugs in temperature-protective coolers with gel packs to ensure that

the prescriptions stay within a safe temperature range — even accounting for if the package is sitting outside for hours after delivery.

Specialty prescription drugs, including injectable drugs with special handling requirements, are usually shipped through commercial mail and shipping carriers, such as UPS and Federal Express. Specialty drugs requiring refrigeration are typically shipped for overnight delivery, often through common carriers other than the USPS.

The safety and efficacy of mailed prescriptions is of utmost importance and is well reflected in the level of precision and planning undertaken by mail-service pharmacies in the mailing of prescription drugs, including those with special handling requirements. The precision also reflects the needs and preferences of consumers not only for safe, high-quality products, but also to know when their prescription will be shipped and received[1]. For example, as required by CMS, Medicare Part D plan sponsors require their network mail-service pharmacies to provide enrollees an approximate shipping date range, of within two-to-three days, prior to delivery.[2] Mail-service pharmacies offer enhanced safeguards for safety and accuracy. Before shipping a prescription to a patient's home, mail-service pharmacies' staff pharmacists electronically review the patient's medications to detect adverse drug reactions, especially any potentially harmful drug-to-drug interactions — even when the patient uses several pharmacies. This information may not be available to a patient's physician without an interoperable health record system.

Specialty pharmacies and mail delivery are tools used in pharmacy networks because they ensure high-quality drug delivery service, avoid waste, and ensure appropriate use of the medications. In limiting a plan sponsor's choices to allow white bagging, this bill is likely to substantially increase costs for Wisconsin consumers and plan sponsors. It is for these reasons we respectfully request that you oppose SB 753.

If you have any questions, please do not hesitate to contact me at hcascone@pcmanet.org.

[1] CMS, "Clarifications to the 2014 Policy on Automatic Delivery of Prescriptions" (December 12, 2013).
[2] Op. cit, CMS (December 12, 2013).

PCMA

Benefits of White Bagging Dispensing

For patients

- **Improved access to care:** "In some circumstances, white bagging can improve access for patients, particularly for patients receiving care with small providers."[1]
- **Improved affordability:** For patients that have not met their medical deductible (in a HDHP), "patients had very high cost-sharing with the buy and bill method."[2] There may be a meaningful cost for patients in terms of their cost sharing (depending on the price of the drug and on the benefit design).

For health care providers

- **Real-time claims billing and payment.** Unlike the medical claims process,[3] pharmacy benefit claims processing is handled in real time so that authorization and patient cost sharing is processed up-front. Patients understand what they are paying, and their health care providers the administration fee they are being paid.
- **Some providers prefer white bagging because the prescriptions come in temperature-controlled packaging,** eliminating the burden and investment of meeting requirements for receiving and storing certain drugs prior to administration. White bagging also may support smaller health care providers to provide this service to their patients without the need to coordinate through a hospital or other outpatient facility.

For employers and other health plan sponsors

- **Specialty pharmacy dispensing on physician-administered drugs ("white bagging") often is much less costly.** There is meaningful savings for employers, other health plan sponsors, and government health care payors when physician-administered prescription drugs are dispensed through a specialty pharmacy instead of a hospital or provider office (using buy-and-bill).
- **"Drug spending exceeds inpatient spending in some cases."** Spending on physician-administered drugs is growing faster than retail drug spending, which "are administered primarily in hospital settings, which drives additional costs on top of the drug costs."[4]
- **"The HPC observed substantially lower commercial prices per unit for Botox, Xgeva and Remicade distributed with white bagging...** In 2013, the per unit price for the drugs ranged from 15% to 38% lower with white bagging than with the traditional buy and bill method, not accounting for rebates."[5]

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[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.
[2] *Ibid.*, Page 3
[3] Providers and hospitals typically only bill through the *medical benefit*, which may have higher cost sharing, generally in the form of co-insurance, for patients. Through white bagging redispensing, the physician-administered prescription can be covered under the *pharmacy benefit*, which may have lower patient cost sharing, depending on the plan benefit established by their health plan sponsor. In addition, the pharmacy benefit processes the claim in real time, which supports patient awareness of their cost sharing *in advance* of the drug being administered; this allows them to make an informed purchasing decision.
[4] Deloitte Center for Health Solutions, Deloitte, LLP, "Drug and inpatient spending lines are crossing," a Deloitte Insights Report (2020), Page 7.
[5] *Op. cit.*, Massachusetts Health Policy Commission (July 2019), Page 3.

Explaining White Bagging Dispensing

Physician-administered drugs are those prescription drugs that are administered by a health care provider to a patient through injection or infusion, and also can be administered in a hospital outpatient setting or a provider's office. These physician-administered drugs are often high priced and represent a growing share of all prescription drug spending nationally.

Dispensing and Payment of Physician-administered Drugs

Option 1: Buy-and-Bill

Known as "buy and bill," the traditional acquisition and payment method for these drugs, the provider – whether a hospital or a provider's office – purchases and store drugs for general use, and payers reimburse the provider for the ingredient cost of the drug as well as for the cost of administration to the patient. In the commercial market, the provider payment amounts for the both the drug and administration are established through payer-provider contracting, and, like all other medical services, are billed under the medical benefit.

Option 2: White Bagging Dispensing

In contrast, under policies implemented by employers, unions, retirement systems, and other health plan sponsors, these health plan sponsors contract with specialty pharmacies to dispense the drugs, removing the provider from the drug acquisition process. The health plan sponsor reimburses the specialty pharmacy for the ingredient cost of the drug and, sometimes, a professional dispensing fee and reimburses the provider for the drug's administration. Since the reimbursement for the drug is not subject to the payer-provider contracting dynamics inherent in the buy-and-bill method, the price of drugs through specialty pharmacies is generally lower.

How White Bagging Dispensing Works

Step 1 The prescription is received by the specialty pharmacy from the prescriber through a secure electronic hub.

The specialty pharmacy reviews the prescription to ensure against drug-drug interactions and other clinical safety concerns.

Step 2 The specialty pharmacy reaches out to the patient or caregiver to:

- Answer any questions about the prescription
- Confirm the patient's consent to the prescription
- Affirm the manner of dispensing, site of administration, and appointment date, including any pre-testing and other clinical safety reminders
- Discuss patient cost sharing and, if needed, financial support

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How White Bagging Dispensing Works (Continued)

Step 3 **Once confirmed with the patient, the specialty pharmacy contacts the provider, at their office or the hospital where the prescription will be administered, to confirm:**

- The patient's information is correct, including their personal health information, diagnosis, the prescription that has been prescribed and dosage amount, and clinical information that may affect dosage (e.g., blood test results, weight)[1]
- When the provider will be administering the prescription to the patient
- When the provider will be available to receive the package, including allowance for the product to be delivered just-in-time following receipt of pre-administration testing results, if applicable, or in advance per the provider's preference*

** Real-time changes in dosage amounts are addressed directly with the provider to prevent against patient delay in treatment and mitigate waste.[2] Physician-administered drugs dispensed by a specialty pharmacy usually are for maintenance medications, where the dosing is well established. Changes in the dosing prescribed by the provider are uncommon.[3]*

- The date of shipment to the provider's office or the hospital and the expected date of signed receipt (same-day as delivery) by the provider or hospital

Step 4 **The specialty pharmacy mails the prescription to the provider or hospital overnight.** The prescription is mailed using temperature-controlled or sensitive packaging in line with US Pharmacopeia guidelines.

- These shipments often involve very specialized shipping containers that have been evaluated by third-parties for the time frames required (e.g., 60-hour pack out, so the prescription is stable for any ambient condition for 60 hours)
- Being prescription- and journey-to-delivery specific, such packaging is very tailored and sensitive to the prescription's handling needs

The provider receives the shipped package without delay following delivery because the specialty pharmacy requires the prescription be signed for by the provider or a designate at time of delivery to ensure chain of custody, pursuant to federal Drug Supply Chain Security Act (DSCSA) requirements.

Step 5 **The prescription is administered by the provider to the patient.**

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[1] This important and critical step verifies that the prescription is the right drug for the right condition for the right person in the right amount; provides an additional layer of confirmation that the dosage amount is correct based on the provider's confirmation, information in the patient record, and, if applicable, the results of any recent patient testing; and ensures patient safety and highest quality care, including through drug utilization reviews and other safety checks.

[2] Waste prevention is a significant area of focus for all health care stakeholders, including employers and other plan sponsors and the specialty pharmacies that they work with. Multiple documented processes and procedures are in place to guard against waste, so that specialty pharmacies are dispensing the precisely accurate prescription and dose.

[3] Most physician-administered drugs do not require blood or other non-weight based clinical testing to ensure the appropriate dose. Weight changes triggering a change in dosing usually must be significant. If a prescription requires blood or other non-weight based clinical testing to ensure the appropriate dosing, the specialty pharmacy will coordinate with the provider to overnight ship an additional vial or hold to ship until after such results are known and confirmed (e.g., blood tests often require a few days to have results).