TONY KURTZ

STATE REPRESENTATIVE • 50th ASSEMBLY DISTRICT

Assembly Bill 718
Wednesday, February 16, 2022
Assembly Committee on Health

Thank you Chairman Sanfelippo and committee members for hearing Assembly Bill (AB) 718 and allowing me to testify today.

AB 718 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 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 patient's 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.

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Assembly Committee on Health
Assembly Bill 718
February 16, 2022

Chairman Sanfelippo and members of the Committee. Thank you for taking my testimony today in support of Koreen's Law.

Representative Kurtz described the reasons for this legislation very well, but I want to give you a perspective that helped me understand why white bagging is a problem for our health care providers in Wisconsin and why I worked with Tony to co-author Assembly Bill 718.

The practice of white bagging may seem complicated, but the system failures it causes and its impact on patients and providers alike are easy to understand. Patients and providers lose control of the products they need for treatment. This would be like forcing customers in my dinner club to use the meat, potatoes, lettuce – and heaven forbid – liquor from a vendor their health insurance company chooses, rather than the normal process that we've depended on for many years.

The vendors are different for everyone based on whom their insurance company chooses, the logistics alone would be unmanageable. I would still be responsible for putting the meal together and making sure it meets the customers' satisfaction, but product quality and timely delivery is quickly compromised when we are forced to receive product outside our normal supply chain. The insurance company refuses to pay me for storage, meal preparation, staff in my kitchen and many other costs that are incurred before the meal is put in front of a customer – even though all these tasks are necessary to prepare a meal.

This scenario might seem feasible for one or two customers. But imagine a packed Saturday night at the Al-Gen in Rhinelander when every other table has a product missing or needs to reschedule their dinner reservation because the product – sent specifically for them - hasn't arrived yet. We cannot use the raw ingredients delivered for another customer or even the ingredients we have on our own shelves – their insurance company prohibits it. We are told there is an exception to this policy which we've never seen, and my staff spends hours on the phone with an insurance company to try to get an exception. The customer is beyond frustrated and ready to leave my supper club, they have occupied a table that could have been used by someone else and now my reputation has been tarnished by this process.

Some customers would leave and never come back. For those that stay, they must choose a different meal – not the one that fits them best or the meal they had in mind when they walked into Al-Gen that night. This is what happens in our hospitals with white bagging, but not with prime rib – with life-saving medications.

I can see from my own business how white bagging is a process set up for failure. Besides the simple logistical problems, these drugs are often time-sensitive and condition-specific – with symptoms getting worse or disease being untreated for every additional hour that unnecessarily goes by.

Today you will hear that the insurance industry has every intention to allow white bagging to grow in Wisconsin. You can clearly see why there is a major problem that needs to be addressed before it gets worse.

I've always been a strong supporter of our state's hospitals, especially those that serve our rural communities in northern Wisconsin. Frankly, I also have been a supporter of our state's health insurance companies. They both have an important role in the health care system. Unfortunately, the practice of insurance-mandated white bagging has gone too far and needs critical guardrails before more patients are negatively impacted.

I ask you to join me in support of Assembly Bill 718.

Alberta Darling
Wisconsin State Senator · District 8

Testimony before the Assembly Committee on Health

Assembly Bill 718

Wednesday, February 16, 2022

Thank you Chair Sanfelippo and committee members for hearing Assembly Bill 718. 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.

Assembly Bill 718 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. Assembly Bill 718 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 Assembly Bill 718. I hope to count on your support for this legislation.

STATE REPRESENTATIVE
JESSE JAMES

February 16th, 2022

Testimony of Representative James in favor of AB 718

I want to thank the Chairman 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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Children's Wisconsin

TO: **Assembly Committee on Health**
FROM: **Chris Spahr, MD, Chief Quality Safety Officer, Children's Wisconsin**
DATE: **Wednesday, February 16, 2022**
RE: **Support for AB 718, 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 be with all of you today 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 across 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 areas like patient safety, quality and pediatric medication management.

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.

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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. Hands off 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 because of the 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.

WMC
Wisconsin's Chamber

TO: Members, Assembly Committee on Health

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

DATE: February 16, 2022

RE: Opposition to Assembly Bill 718

Wisconsin Manufacturers & Commerce (WMC) appreciates the opportunity to comment on Assembly Bill 718. 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 AB 718, eliminates employers' ability to innovate and provide quality, low cost health care to their employees and their families.

AB 718 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 shows that 83% of hospitals charge patients

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[1] WalletHub, Best and Worst States for Health Care: https://wallethub.com/edu/states-with-best-health-care/23457

and insurers more than 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 AB 718 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 to promote innovation and price transparency in order to create more competition, not less.

WMC urges members of the Assembly Committee on Health to oppose this interference in private contracts that will take away an important tool for employers throughout Wisconsin to contain the costs of health care, while creating a monopoly in the market for clinician-administered drugs.

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[2] The Moran Company, Hospital Charges and Reimbursement for Medicines – Analysis of Cost-to-Charge Ratios: https://www.themorancompany.com/wp-content/uploads/2018/09/Hospital-Charges-Reimbursement-for-Medicines-August-2018.pdf

[3] PLANSPONSOR, Employers Remain Optimistic About Health Benefits Despite Higher Projected Costs: https://www.plansponsor.com/employers-remain-optimistic-health-benefits-despite-higher-projected-costs/

Correspondence Memorandum

Date: Thursday, February 10th, 2022

To: Assembly Committee on Health

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).

Given the significant prices, employers and their employees are bearing the brunt of this on-going burden. For employers and Wisconsin economic development, this 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
Dashir Management Services

hoffmaster Group, Inc.
Team Schierl Companies
Schierl Tire Service
Wysocki Family Companies
Enerquip
Midwest Carriers
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

Morrow Home Community
The Weber Group
Tractor Central
Kapur and Associates, Inc.
Robinson, Inc.
Bill's Distributing, Ltd
Weldall Manufacturing
Alwin
Deluxe Plastics
Palmer Fixture
E-Z Tape
Rowley Tool & Die
Forest Tool
M&M Tool and Mold
Allied Plastics, Inc.
A&E Tools
Bell Ambulance
Astia Health
Waupaca Foundry, Inc.

GS Global Resources
Blain's Farm & Fleet
Redline Plastics
The DeLong Co., Inc.
New Life For Work
MRA
Dowco Powersports
RF Technologies, Inc.
Jack Link's
LDI Industries, Inc.
J. J. Keller & Associates, Inc.
Lakeside Foods
Sendiks Markets
Wolter Inc.
Promega Corporation
LaForce, LLC
Poclain Hydraulics Inc.
Backsmith Advanced Physical Therapy, LLC
Merrill Steel, Inc.

Coalition of Wisconsin Employer Groups Concerned About Health Care Costs

TESTIMONY IN OPPOSITION TO AB 718

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

ASSEMBLY COMMITTEE ON HEALTH

FEBRUARY 16, 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.

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.

9. 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.

10. 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.[3]

11. 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

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

profits" by acquiring these specialty medications at a discount under the federal 340B Drug Pricing Program.[6] 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.

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. 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 first quarter of 2021.[8] Walker Forge and Purdue University

[6] https://www.marwoodgroup.com/wp-content/uploads/2021/11/White-Bagging-Whitepaper-11_24_2021.pdf p.3
[7] Ibid., p.3
[8] https://www.indianaruralhealth.org/clientuploads/Advocacy/HEA_1405_Specialty_Drug_Report_July_2021.pdf

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 that if this legislation passes and becomes law, self-funded employers may be left with no other choice but to exclude certain high cost medications from coverage. A majority of Wisconsinites are insured through employer plans that can design their own benefits, and these employer plans have discretion 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

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.

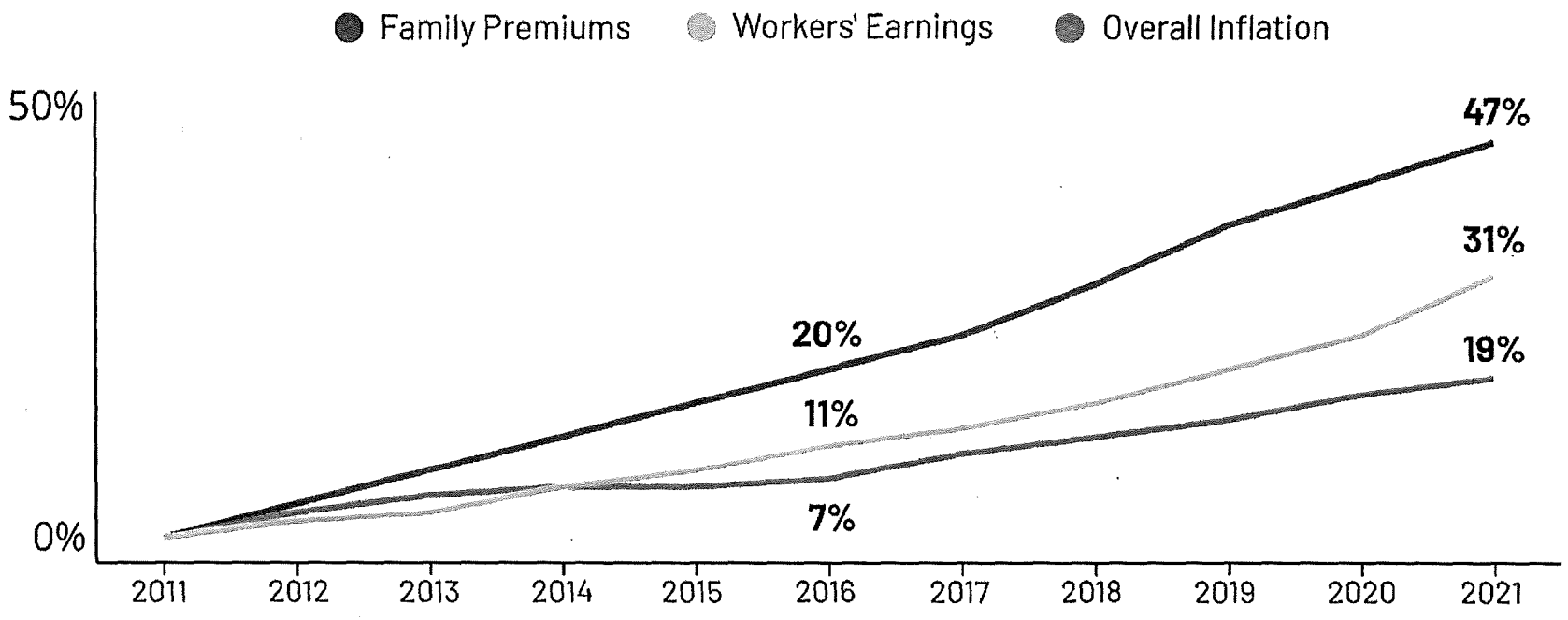
"There is nothing hidden here, and I give Rand a huge credit for that," he said. "You do not usually see this amount of backup information in a study such as this."

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."

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

Thank you for having me and allowing me the opportunity to testify in support of Koreen's Law. My name is Koreen Holmes and this is my husband Nathan. Together we have a beautiful 3 year old girl and a handsome 1 year old little boy. This white bagging policy has drastically impacted my life and many others around me. There wasn't a doubt in my mind to lend my name to a legislation to hopefully help ban this practice.

My story started in December of 2020 at 30 weeks pregnant when I realized something in my breast was off. What started off as what we thought was mastitis a week later became stage 3 TNBC. What I didn't know then was the differences in breast cancer. I thought bc was just that. TNBC means I don't have as many treatment options as someone with a receptor positive hormone. It means its aggressive and it grows fast. It means that the treatment that is available is treatment that I need to survive.

I delivered my baby at 36 weeks and the following week I started treatment. I was lucky - insurance wasn't a huge issues, I was handling treatment fine, I had an amazing support system and everything was looking good. Halfway through my treatment I received a phone call from my cancer center telling me that I was being denied treatment that I was already taking for the last 6 months. I needed to call my insurance company and fight to get approved so that I could finish my treatment. Treatment that I needed to live.

I spent 2 hours on the phone with a lady from the insurance company who had no idea what I was talking about. She had never even heard of white bagging and needed to get more information. I spent 2 hours talking on the phone crying, stressing and frustrated. What cancer patient, or any patient for that matter, should have to deal with that? Why is it MY JOB to inform insurance what I'm being denied of and what this practice even means when I didn't even know myself?

Insurance had said that they tried contacting me but not once did I hear from them. In fact the lady I spent time on the phone with said shed call me the following week and I was the one who had to reach out to her twice. She still had no answer for me. It wasn't until October 2021 that I got another call from my cancer center saying that I was being denied and there was nothing else they could do for me and I had to take the matter into my own hands.

At this time I was in Madison getting radiation and there was nothing I could physically do. I called my husband and left a message bawling telling him how he needed to drop everything he was doing from work to help fight for me. Keytruda,

the treatment I was fighting for, is every 3 weeks and I was approaching my next deadline.

I don't understand how this is okay. Not only am I a mom and a wife, but I'm a daughter, sister and a young cancer patient. And Im just one person - think of how many others are going through this. The others that don't have a voice, others that don't have support and others who can't do anything about it and will just give up entirely.

I have been with my team since January 2021 and the thought about leaving them or having to drive x amount of miles to receive treatment was a scary thought. As a cancer patient its crucial that you have faith and trust in your team and that's exactly what HSHS gave me. Faith and trust. They became my family.

Im asking you all to please support Koreen's Law. This might not make sense to some of you but hear the testimonys - put yourself in my shoes for the day and understand what this does to not only us patients but to the support team we have. Fighting cancer is scary - its life or death. Fighting any condition is scary. Then going through something like this? Its traumatic. Im thankful that I can say that I beat this but will the next person be able to say the same? Will they get their medications on time? Will they have to travel to get treatment or have to find a new team? As someone who has experienced this first hand this is very real. Thank you so much for your time.

Nate: Introduction

Assembly Committee Members, thank you for the opportunity to testify in front of you today. We 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 should not be allowed.

This was an extremely tough time for our family - navigating a cancer journey, welcoming our second child, settling into a new home, all while a pandemic raged on. I am the primary provider for our family. My compensation is soley based upon commission and the effort I put in daily which involves a lot of travel, and hours away from my home and family. This can be enough stress by itself while trying to care for our children and be involved as much as possible with my wife's cancer treatment.

Then, suddenly we were faced with a barrier that came out of nowhere and left us navigating a complicated medical/ insurance system and becoming our own advocates at one of the most challenging times in our life. We started fighting even harder for my wife's life in a race against time - let me take you through my experience firsthand.

I received a voicemail from Koreen while I was at work one day. There is nothing worse than getting a voicemail from your wife who is bawling and completely distraught telling you she needed you to drop everything from work and help her out immediately.

I met with Jess, Angela, and other hospital staff early on a Friday morning in Oct. When I arrived at the hospital, I was not 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 do whatever it took to continue getting her care.

I called the 800# on the back of my insurance card. We were listening to the phone tree with hope to hear a prompt to speak to someone about this new "White Bagging" policy. After being connected, I asked to speak to someone about "White Bagging" 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. As you can imagine we were increasingly more frustrated and disappointed with each transfer. I would retell my whole story over from the beginning with each transfer to each different dept./ representative. We were transferred 6 different times and exhausted a full 6 hours on the phone.

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 an effort to continue her care with the team we grew to love, and trust. It was 3:30 on a Friday afternoon; what happened next is what felt like a Miricale. Angela, had received a notice by email that continuity of care was granted for 90 days!!! We were ecstatic, celebrating, and although we achieved the outcome, we were seeking I cannot explain how much stress, worry, and anxiety was riding on this day.

To think about what others who do not have a care team like ours or have a voice in the matter go through is truly devastating. We were

also informed that no further appeals would be granted. Meaning someone in the beginning of a cancer diagnosis, or other critical illness could be turned away and refused treatment with no other options! It is for this reason we are here to help ensure that this does not continue to happen to others less fortunate than us.

Nate: Conclusion

Please support Assembly Bill 718 to protect patients in the state of WI at a time they need you the most! Although many policies are influenced or driven from projected cost savings, or potentially improved efficiency, this is not one of them! Quite honestly "White Bagging" does the opposite. The bigger issue that is being overlooked is the well-being of PEOPLE. Real People, like you, me, Koreen, and your constituents. Unfortunately, there are already many stories like ours across Wisconsin. My fear is if you do nothing to stop this, there will be many more and not all of them may have the positive outcome ours did and ultimately could be at the expense of someone's life.

Thank you for your time.

Testimony Before the Assembly Committee on Health
Koreen's Law – Assembly Bill 718

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

February 16, 2022

Chairman Sanfelippo, Ranking Member Subeck and members of the Assembly Committee on Health. My name is Joanne Alig and I am the Senior Vice President of Public Policy for the Wisconsin Hospital Association (WHA).

I would like to thank you for the opportunity to testify in support of Assembly Bill 718, 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 Assembly Bill 718 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 imposing a unilateral mandate on providers. In some instances the insurer simply decides certain drugs will be white bagged. In other instances, insurers will say they give a choice. But a seeming choice of take this price or we will impede care for your patients through white bagging is effectively no choice – it is a mandate.

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, AB 718 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 AB 718'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 AB 718 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, you have previously expressed support of the exact issues that are at the very core of Assembly Bill 718, including care coordination and patient safety. We are asking you to also today support of Assembly Bill 718. 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 Assembly Committee on Health
2021 Assembly Bill 718 – "Koreen's Law"
February 16, 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 Assembly Bill 718.

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. Harm due to 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. Some of 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 Assembly Health Committee
2021 Assembly Bill 718 – "Koreen's Law"
February 16, 2022

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

Thank you for this opportunity to provide written testify in support of Assembly Bill 718 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. However, population-based decisions are not always right for individual patients. Pharmacists and physicians need to be able 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 Assembly Bill 718. 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. Assembly Bill 718 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 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.

Kate is now in the sixth month of her injections and the process has never run smoothly. Just this week, I have spent hours on the phone trying to get Kate's next injection. I have called the specialty pharmacy three times and our allergist's office twice. Lack of communication and changing information and requirements means that Kate's next injection will not happen on time. We now need to make a plan to manage any breakthrough hives that may happen because of her delayed treatment. And since this month's injection still isn't scheduled, I will need to make several more time-consuming phone calls until the issue is rectified.

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 and stressful. 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 my daughter and the Pharmacy Society of Wisconsin, I want to reiterate my support of Assembly Bill 718. This important bill aligns with PSW's goal of keeping patients' best interests at the forefront of our work and decision-making.

Sincerely,

Melissa Theesfeld, PharmD

Melissa L. Theesfeld, PharmD
Board Chair
Pharmacy Society of Wisconsin

Assistant Dean for Clinical Affairs & Director of Experiential Education
Associate Professor Pharmacy Practice
Concordia University School of Pharmacy
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Reedsburg
AREA MEDICAL CENTER

FROM: Hannet Tibagwa Ambord, Pharm D. MS. MBA,
Director of Pharmacy, Reedsburg Area Medical Center
DATE: February 16, 2022
RE: Support Assembly Bill 718 – Protecting Patients from Mandated Insurance Practices

Representatives, thank you for the opportunity to testify today on behalf of Reedsburg Area Medical Center (RAMC). My name is Hannet Ambord. I wanted to become a pharmacist when I was 6 years old. 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.

I want to tell you about my patient Karen. She is 78 years old and coming to the clinic takes major coordination on her part. We scheduled her wellness visit along with her treatment for her inflammatory condition. At her wellness visit, we had to tell her that this time we could not administer her injectable medication as we have always done, even though we had the drug, and are in network to provide services and other drugs, but not this specific drug because it was white bagged – that's 2 visits instead of one. This is increasing the overall cost of healthcare.

Christine is 53 years old and has been coming to RAMC for years to receive care for a debilitating condition. We decided to try white bagging with her and I have to tell you that not only was it embarrassing, it was a troubling experience. Christine's 1st dose arrived 5 days later than scheduled, the 2nd dose was 10 days late, 3rd dose was 1 month and 7 days later than her appointment, the 4th dose never came. I spoke to her to find out what was going on. The back and forth with the specialty pharmacy took a toll, and she decided to stop treatment. Christine's treatment was interrupted, her quality of life was diminished, and in the end she will have a worse condition, guaranteed. When insurers disrupt patient-provider relationships, our patients suffer.

Representatives, we are messing with people's lives and are holding them captive. At my hospital if patients cannot afford their medication, patients are put on a payment plan, and we still give them their medications. Colleagues have shared that certain specialty pharmacies will not release their medication upfront until the patient pays their co-pay or co-insurance in full.

You will hear today from my friends that they have a tiered structure that they have presented to us. The tiered structure was essentially a requirement that we accept a much lower reimbursement by a certain date or this is the list of medications that would be white bagged. They were not willing to negotiate. I have had the opportunity to collaborate and partner with local employers and payors and we have saved them a lot of money. Yes, when we get drugs, we mark them up by a certain percent to account for our costs for handling and preparation, but at the end of the day the insurer sets the payment rate through the contract. If I charge $100 dollars and they decide they are going to pay me $50, even if I increase my price to $125, they still pay me $50.

When 66% of doses are wrong and 88% of the doses do not ship in time, patients suffer. RAMC will need to hire more people to manage this process, add more storage to already tight spaces, the quality gaps being introduced in the procurement and preparation of these medications is a major concern, fragmented patient medical records, the implied liability, and the increased cost to the overall healthcare are red flags. We are here to sound the alarm; it is going to get worse for patients if nothing happens.

Testimony of Jordan Dow, Director of Pharmacy Services,
Mayo Clinic Health System, Northwest Wisconsin
In Support of Assembly Bill 718

Representatives,

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.

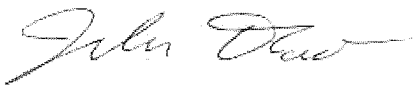
Also, our patients are people like all of us, and their conditions change, so they may need a change in their treatment.

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,



Jordan Dow

Testimony before the Assembly Committee on Health
2021 Assembly Bill 718 – "Koreen's Law"
February 16, 2022

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

Chairman Sanfelippo and members of the Assembly Committee on Health, thank you for the opportunity to testify before you today in support of Assembly Bill 718. 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 Assembly Bill 718. Thank you

Testimony Before the Assembly Committee on Health
Koreen's Law – Assembly Bill 718

February 16, 2022

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

Mr. Chair and Committee members, 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 and my practice focuses on health law issues affecting hospitals and pharmacies across the country.

The WHA team asked that I discuss with the Committee core legal considerations that Koreen's law is intended to address.

White bagging requires significant additional pharmacy and pharmacist involvement beyond what is required in the traditional institutional model for safe handling, preparation and administration. However, only limited administration fee reimbursement is available. Meanwhile, a dispensing pharmacy that often has a financial relationship with the mandating payor retains dispensing fee and ingredient cost revenues.

Still, white bagging does not reduce the need for hospital pharmacy and pharmacist oversight. In fact, it increases administrative burdens and legal risks. This places managing pharmacists in the position of having to carefully monitor, and take on most of the responsibility and risk for, a 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, due to the hospital's involvement.

For pharmacists who are professionally responsible for the administration of safe, unadulterated drugs, this results in a massive administrative and ultimately personal burden. This burden includes ensuring that manipulation of a dispensed prescription is only performed in accordance with FDA-approved instructions.

While this may seem straightforward, determining whether or not manipulation of a drug is consistent with FDA-approved labeling is highly technical and patient safety is very much at issue. 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. 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, the reimbursement is significantly reduced based on the false premise that the drug has already been "dispensed."

Therefore, while white bagging has been positioned as a cost-savings mechanism, at best it serves to actually 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. I would be happy to discuss specific examples today at the Committee's request but will not right now in the interest of time.

Ultimately, white bagging puts 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.

In modern payor contracts, drugs are not paid on the basis of charges. Rather, fee schedule rates are negotiated. A discussion of hospital charges, therefore, is not relevant. Hospital reimbursement, however, is worth considering and it is clear that white bagging diverts reimbursement away from hospitals while increasing overall costs to safety net hospital patients and their supporting communities.

Many hospitals have payor contracts that they believe prohibit white bagging models. However, large payors will put forth contract interpretations that many providers would characterize as a circumvention. While litigation is theoretically possible, as a practical matter this is rarely a viable option due to payor organizational complexity and resources. More, hospitals work on such small margins it is not reasonable to expect them to forego reimbursement during the course of litigation that could last for years.

I would like to note that this proposed law is cognizant of the fact that white bagging can be appropriate in certain circumstances and does not prohibit the continued use of prior authorization processes. I would also like to point out that the overwhelming majority of Wisconsin hospitals are tax-exempt, non-profit entities. These organizations must annually report charity care expenses, community building efforts, bad debt expenses, organizational structure and facility information. A review of this information shows that, unlike for-profit payors, a material portion of 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.

Specifically, Congress enacted the Emergency Medical Treatment and Labor Act (known as "EMTALA"). 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. 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.

The continued availability of health care access in our underserved communities, whether rural or urban, is being severely impacted. This is why multiple states have already passed very similar laws, with still more under consideration. We therefore respectfully request your support of Senate Bill 753.

HSHS WISCONSIN

HSHS St. Vincent Hospital
Green Bay

HSHS St. Mary's Hospital Medical Center
Green Bay

HSHS St. Nicholas Hospital
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HSHS St. Clare Memorial Hospital
Oconto Falls

HSHS Sacred Heart Hospital
Eau Claire

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Testimony before the Assembly Committee on Health
2021 Assembly Bill 718 – "Koreen's Law"
February 16, 2022

Andy Bagnall, President and CEO
HSHS Wisconsin

HSHS WISCONSIN

Chairman Sanfelippo and members of the Assembly Committee on Health, thank you for allowing us the opportunity to testify today in support of Assembly Bill 718. 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. As you know Rep. Summerfield, HSHS St. Joseph's Hospital in Chippewa Falls is in your district & many of those patients travel quite a distance from rural areas to receive our advanced level of care. 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.

I believe white bagging, unilaterally instituted by insurance companies, is moving health care delivery backwards for patients, greatly increasing the chance of error and driving patients away from the care teams they trust.

Patient Safety is our top concern – it's what we as a health care system are trusted to do every minute of every day. A hospital is where patients should feel comforted and safe in expert hands.

That was the case for Koreen Holmes. You heard how vested she was in her health care team at the cancer center within HSHS Sacred Heart Hospital in Eau Claire. Then she was told she may have to switch care teams. Suddenly white bagging became as important to her as her fight with cancer.

Koreen is not alone – there are many more Wisconsinites facing cancer, rheumatoid arthritis, multiple sclerosis, macular degeneration, blood disorders, Chrohn's Disease and other conditions that require medications that are on the white bagging list.

Since the white bagging policy began, nearly 50 patients at HSHS Wisconsin hospitals have been impacted.

Quality of care & Care Delivery is also a top priority for HSHS.

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.

HSHS WISCONSIN

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. This is *not* high quality of care.

This is a real scenario for some of our patients:
Many GI patients have had treatment delays of 1 week or longer, because of white bagging. 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.

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 many providers do not have capacity to accept patients who do not have established care with them.

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.

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 or eliminate excruciating pain. In Koreen's case – she and her husband didn't even know what to ask for. But our health care team as HSHS helped them with every step in the confusing process.

In conclusion, patient safety, quality of care and care delivery are compromised if white 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.
This has resulted in 10 potential patients deciding to find care elsewhere after they learn their drugs may be on the white bagging list.

HSHS WISCONSIN

The consequences of white bagging and brown bagging implemented unilaterally by insurance companies outside contract negotiations, are creating substantial care-delivery 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. I ask for your support of Assembly Bill 718. 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.

Please support Koreen's Law. Thank you.

RWHC
Your partner. Your source.

TO: Assembly Committee on Health
Representative Joe Sanfelippo, Chair

FROM: Tim Size, Tim Size
Founding Executive Director

DATE: February 16, 2022

RE: SUPPORT Assembly Bill 718—Protecting Patients from Mandated Insurance Practices

Begun in 1979, the Rural Wisconsin Health Cooperative (RWHC) is owned and operated by forty-five rural community hospitals. We support Assembly Bill 718 because we believe it will help to protect our patients from insurance company practices that can harm and frustrate their access to local care.

Rural hospitals and clinics have a long tradition of assisting their patients in navigating arcane health insurance rules and regulations. Health insurance companies should work with us, not undermine us, so that their enrollees can receive the care they need close to home.

RWHC believes that white or whatever color bagging comes with risk to the patient and forces patients away from their trusted, local care team when they need them the most. Several of the national insurers have already implemented white bagging and regional and local insurers are following suit.

We see white bagging as an acceleration of health insurers fragmenting the care available in our rural communities–removing imaging services, lab services, and other specialty services–all eroding the ability of our rural hospitals and clinics to stay open.

It is the responsibility of us all to think about the health care available in rural Wisconsin. While our hospitals have been fighting for the lives and well-being of their communities and staff, we have never been under greater threat from some health insurers who, not satisfied with record-breaking profits, have become even more aggressive.

When we challenged this trend, I was told by a spokesman for health insurers that it wasn't his job to worry about rural health care. I couldn't disagree more. It is all of our business to worry about rural health care.

Thank you for the opportunity to offer our support for the Assembly Bill 718. We encourage the Committee to act on the bill so that it might become law and more can be done to help maintain local healthcare in rural Wisconsin.

880 Independence Lane • Sauk City, WI 53583 • (608) 643-2343 • Fax (608) 643-4936 • www.rwhc.com

RWHC
Your partner. Your source.

TO: Assembly Committee on Health
Representative Joe Sanfelippo, Chair

FROM: Michael Ballinger
Director of Insurance Contracting – Rural Wisconsin Health Cooperative

DATE: February 16, 2022

RE: SUPPORT of Assembly Bill 718—Protecting Patients from Mandated Insurance Practices

Chairman Sanfelippo and Committee members, thank you for the opportunity to testify in support of Assembly Bill 718.

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. My role includes contract negotiations with insurance companies and helping our hospitals navigate the ever changing managed care landscape and related insurer policies.

Our hospitals are already in-network with the payers and have contracts that have established rates for specialty drugs. The payers that have implemented white bagging haven't done so 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.

It is also important to note that the list of drugs included under the respective payer polices are subject to change at the payers' sole discretion. 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.

During the Senate hearing, some of the payers testified of having an exception process for white bagging, with one payer even indicating that they have an exception form. I have dug through the various payer's web-sites, policies, bulletins, and letters and wasn't able to find a single mention of exceptions.

One payer web site did have notices about their specialty pharmacy program in April 2021, June 2021, and October 2021 with nothing to be found in any of the 3 of any exception process, let alone an exception form. Maybe just me, but seems kind of senseless to have an exception process if it's not communicated or users can't find any information on it or how to use.

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Coincidentally, 2 of the 3 notices mentioned above had updates of additional specialty medications being added to the list of drugs under their specialty drug program. Ten new drugs added within 3 months of the program being implemented for one insurer alone- as mentioned, not a one and done change.

Even if a patient knew that an insurer required white bagging and did everything they could before enrolling in a plan, checking if a drug that were using was on the list or if they could continue to get from their local provider, all that can change with a single "notice" in the middle of their plan year resulting in something different than what they thought they were signing up for which is just not right.

The health insurance plan that my employer offers implemented white bagging July 1, 2021, which was in the middle of our plan year. As a subscriber, I received no notice from the insurer that they implemented white-bagging – no letter, no email, nothing on the patient portal. I inquired with our HR benefits person if they, as the employer/plan sponsor, were notified of this change or if we got any sort of refund of premium dollars for savings that would be incurred from white-bagging – the answer was "No" and "No". Prior to our 2022 renewal, I asked HR if there was anything in our renewal notice regarding white-bagging or if there reduction in premium costs resulting from specialty drug claims - and the answer was once again "No" and "No". If white bagging is such a good tool and no concerns of safety, quality of care, or access, why the lack of communication? Why don't they want their customers, employers or patients, to know?

I will leave you with the following in closing.

Wisconsin Statute 632.375 - Motor vehicle repair practices; restriction on specifying vendor, specifically states ***"No insurer may require that, as a condition of the coverage that repairs to a motor vehicle be made by a particular contractor or repair facility"***

I hope that you would agree that a consumer's health or life is far more important than their car, and if they can't be required to get their car fixed by a particular repair facility, they shouldn't be required to get their infusion medication from the insurers designated pharmacy either, especially when the provider that the patient wants to use is otherwise already contracted and in-network.

I respectfully ask that you please support Assembly Bill 718 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. Thank you.

N17 W24340 Riverwood Drive
Waukesha, WI 53188

March 26, 2021

VIA UPS DELIVERY RECEIPT REQUESTED

[redacted]

- No mention of Exception Process -

RE: Designated Specialty Pharmacy Network

Dear [redacted]

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. Your hospital(s) listed below is **not** included in this Designated SRx Network.

[redacted]

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.

To access the current [redacted] visit [redacted] select *Providers*, select the state Wisconsin (top right of page), select *Forms and Guides* (under the *Provider Resources* column), Scroll down and select *Pharmacy*, in the Category drop down.

Sincerely,

Scott Gerhart
Regional Vice President, Provider Solutions
Anthem Blue Cross and Blue Shield

Anthem Blue Cross and Blue Shield is the trade name of Blue Cross Blue Shield of Wisconsin (BCBSWI), Compcare Health Services Insurance Corporation (Compcare) and Wisconsin Collaborative Insurance Company (WCIC). BCBSWI underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare or WCIC. Compcare underwrites or administers HMO or POS policies. WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association.

— No mention of exception process —

Designated specialty pharmacy network*

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.

To access the current Designated Medical Specialty Pharmacy Drug List, visit anthem.com, select *Providers*, select the state Wisconsin (top right of page), select *Forms and Guides* (under the *Provider Resources* column). Scroll down and select *Pharmacy* in the Category drop down.

1043-0421-PN-WI

Featured In:

April 2021 Anthem Provider News - Wisconsin

them Blue Cross and Blue Shield is the trade name of: In Colorado Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health P Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Mair ssouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates adr n-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite bene vada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO pla ministered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, I Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue : sconsin (BCBSWI), which underwrites or administers the PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare or WCIC. Compcare Health Services

Designated specialty pharmacy network updates

- No Mention of Exceptions -
- New Drugs added -

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

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 June 30, 2021, the following specialty pharmacy medication 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 this specialty medication administered in the hospital outpatient setting from CVS Specialty Pharmacy.

HCPCS	Description	Brand Name
Q5121	INJECTION, INFLIXIMAB-AXXQ, BIOSIMILAR 10MG	Avsola

Effective immediately, the following specialty pharmacy medications have been **removed** from the Designated Medical Specialty Pharmacy drug list:

HCPCS	Description	Brand Name
J0178	EYLEA	Eylea
J0588	INJECTION INCOBOTULINUMTOXIN 1 UNIT	Xeomin
J2353	INJ OCTREOTIDE DEPOT FORM IM 1MG	Sandostatin LAR Depot
J1930	SOMATULINE DEPOT	Somatuline Depot

To access the current Designated Medical Specialty Pharmacy drug list, please visit anthem.com, select *Providers*, select your applicable state, under the Provider Resources column select *Forms and Guides*, scroll down and select *Pharmacy* in the Category drop down.

Note that the Designated Medical Specialty Pharmacy drug list may be updated periodically by Anthem.

If you have questions or would like to discuss the terms and conditions to be included as a Designated Specialty Pharmacy Network provider, please contact your Anthem Contract Manager.

Thank you for your continued participation in the Anthem networks and the services you provide to our members.

1199-0621-PN-IN.WI

URL: https://providernews.anthem.com/wisconsin/article/designated-specialty-pharmacy-network-updates-1

Featured In:
June 2021 Anthem Provider News - Indiana, June 2021 Anthem Provider News - Wisconsin

Anthem

- No mention of Exception Drugs -
- New Drugs added -

Designated specialty pharmacy network updates effective January 1, 2022*

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

To access the current Designated Medical Specialty Pharmacy drug list, please visit anthem.com, select *Providers*, select *Forms and Guides* (under the Provider Resources column), select your state, scroll down and select *Pharmacy* in the Category drop down. The Designated Medical Specialty Pharmacy drug list may be updated periodically by Anthem.

If you have questions or would like to discuss the terms and conditions to be included as a Designated Specialty Pharmacy Network provider, please contact your Anthem Contract Manager. Thank you for your continued participation in the Anthem Networks and the services you provide to our members.

348-1021-PN-IN.MO.OH.WI

Featured In:

October 2021 Anthem Provider News - Wisconsin

Fort HealthCare
FOR HEALTH

The Honorable Joe Sanfelippo
Chair, Assembly Committee on Health
Room 417 North, Wisconsin State Capitol

February 16, 2022

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

Chairman Sanfelippo and members of the Assembly Committee on Health, 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. 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.

Chairman and Representatives, thank you for your time today.

Sincerely,

Carl Selvick

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

Cc: Members; Assembly Committee on Health

AdvocateAuroraHealth

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February 16, 2022

Testimony to the Assembly Committee on Health
Support for Assembly Bill 718
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 Sanfelippo and members of the committee – thank you for the opportunity to provide testimony in support of AB 718. 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.

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.

****

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.

****

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

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arrange payment. The most recent message our office received from this patient states that he needed to reschedule his 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 AB 718.

Ascension

Testimony before the Assembly Committee on Health

2021 Assembly Bill 718 – "Koreen's Law"

February 16, 2022

Testimony provided by Vanessa Freitag, Vice President of Pharmacy and Lab, on behalf of Ascension Wisconsin

Dear Chairperson Sanfelippo, Vice Chair Summerfield 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 AB 718, 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 patient care,
- **Requires patients to pay** sometimes exorbitant, upfront co-payments before they can receive care, and
- **Causes immense confusion and frustration** for patients who must navigate an overly-bureaucratic process for ordering critical, sometimes life-saving medications through an outside third party specialty pharmacy.

AB 718 would **prohibit** this practice, ensuring patients have timely access to necessary medications through their own health care provider, are able to benefit from medication discounts, financial assistance and charitable programs that are initiated or offered directly through hospitals, and maintain an uninterrupted 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 since been communicated inconsistently, and are implemented outside of negotiated agreements. The lack of transparency offers Ascension Wisconsin care team members little time to prepare for the changes 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 are often those who are medically acute and in the midst of treatment for a range of serious conditions including cancer, neurological diseases and other acute illnesses.

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. This creates financial hardship for patients juggling multiple medical expenses and often delays in care for individuals with financial limitations. 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 in applying for the drug discount programs for which they qualify, causing them to miss out on crucial savings for costly medications. We 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 so they can focus on healing.

Duplication and Errors in Medication Orders: Placing orders for medications is part of the standard of care we provide while patients are undergoing treatment within our facilities. "White bagging" practices require our patients, who are often sick and feeling depleted, to navigate their medication orders through third party specialty pharmacies. Some of these patients are cognitively or medically impaired or in the advanced stages of their disease and cannot easily 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. Additionally, many patients have labs drawn the same day as treatment and 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:
"White bagging" is inefficient and adds costs to the healthcare delivery system. 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 "white bagging" is inefficient and challenging for healthcare providers, our patients have the most at stake. Outlined below are just a few of many Ascension Wisconsin patient experiences with "white bagging."

- Patient with Autoimmune Disease Denial of Coverage: An Ascension Wisconsin patient with an immune deficiency disorder was undergoing immunoglobulin treatment with his provider for several years. The patient changed insurance providers in January 2021. On July 5, 2021, the patient received notification that the medication claims were denied by their managed care organization (MCO). The patient decided to delay care due to concerns about the costs of receiving medication that was no longer covered by the insurance company. This was the only treatment option available for this patient. After months of advocacy, including 25 documented phone calls to the MCO, we finally received approval to administer the medication in September 2021. We have since had

to continue assisting this patient in navigating his benefits as copay responsibility is now in question. Bottom Line: Attempts to "white bag" this patient's medication has resulted in a months-long disruption of care and countless hours spent by the patient, family members and providers trying to secure the only treatment option available to this patient.

- Patient with Breast Cancer High Copayments: An Ascension Wisconsin patient with breast cancer was undergoing treatment with a drug called 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 and she paid more than what was required. 'White bagging" of this medication placed undue financial hardship on the patient, threatened the course and timeliness of her treatment and has caused her tremendous emotional distress. Ascension Wisconsin's care team was 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: An Ascension Wisconsin patient who was under treatment for severe and chronic migraines that occurred as part of a neurological disease, had been issued a doctor-ordered increase to their medication dosage. Ascension Wisconsin 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, the clinical staff reached out several times to numerous phone numbers given by the insurer. The specialty pharmacy did not have a consistent customer service number. Calls repeatedly 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 by the pharmacy, there were shipping delays and the drug was received two days after it was scheduled to be received at the patient's site of care. 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.

Ascension Wisconsin's patients are facing significant challenges as a result of "white bagging." As this practice is implemented outside of contracting and policy agreements, providers and patients are unable to adequately prepare for changes that have far-reaching consequences to the costs of and continuum of vital medical care.

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. On behalf of Ascension Wisconsin, I respectfully request your support for AB 718.

Thank you for allowing me to testify today.

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

bellinhealth

Official Healthcare Partner of the Green Bay Packers

Bellin Health
Jim Dietsche
Testimony for Koreen's Law SB 753
Senate Committee on Insurance, Licensing and Forestry

Madame Chair and Senate Committee members,

Thank you for the time today. It is sincerely appreciated. My name is Jim Dietsche. I am the Executive Vice President and Chief Financial Officer of Bellin Health based in Green Bay and have been in this role for nearly seventeen years. Bellin Health serves 12 Wisconsin counties in Northeastern Wisconsin and those counties have a population of about 625,000 people. Bellin has approximately 40 different locations including clinics, ambulatory surgery center, urgent cares, and hospitals spread throughout that geography. We employ over 5,000 individuals whose focus is to provide the highest clinical level of care with the best possible outcome and experience of care at the lowest cost, what we call the Triple Aim.

Today, you will hear from many colleagues of mine on the challenges individuals (patients) face as it relates to appropriately receiving a very important clinical medicine delivered in a safe and appropriate fashion to protect the integrity of the delivery of often times life-saving drugs.

In my role as a finance person, I would like to briefly discuss two financial issues surrounding the current challenges that we face today by allowing the use of white-bagging.

The first is the financial impact to the provider of care. There are several components to the delivery of an infused medication – components that must be part of the process whether a drug is white-bagged or not. The difference is that white bagging doesn't account for these costs, and in fact increases the amount of time and thus cost involved. Besides the drug itself, our organization will incur the cost of the pharmacist, a pharmacy technician, a nurse to administer and monitor the patient, an authorization specialist and financial counselor to ensure the medication is covered by the individual's benefit plan. And then we incur other costs related to support the actual safety and administration of the drug including infection prevention and quality and safety teams to ensure a highly reliable system. In a white bagging environment, the only thing allowed to be billed for services is a nursing administration code to deliver the medication. That payment does not cover the cost of all the services necessary to safely administer the drug. The way those costs are normally covered is in the acquisition of the drug itself which would include a small markup to cover those costs. When an organization signs a contract with an insurance company, there is a negotiation process for all services provided under the contract including these high cost drugs. What is happening today with white bagging is that insurance companies are unilaterally changing a policy which does not allow the beneficiary of their plan to receive this drug from their provider of choice. We are not allowed to provide that service to their member after they change their policy and if we do provide the service, we will not be paid for the cost of the drugs. I have two examples of patients named Catherine and Steve who both live in Oconto County who need the following drug called Lupron

and Neulasta which are used in support to the treatment of cancer in which we provided the medication to patients and were unable to be reimbursed by the insurance company. The cost of the drugs in these two examples alone were over 41,000 and in these situations our organization did not bill the patient. Therefore shifting the cost to the provider.
Insurers implement white bagging outside of the normal contract process. Specifically Bellin has negotiated in good faith with one major insurance company and we have agreed to a fixed payment rate for these drugs which means the insurance company has not implemented the use of white bagging with us even though we know they have implemented with other health care providers in our region. Insurers will often tell you that payment is on a percentage of charge basis. That simply is not true for the vast majority of healthcare systems. The payments are a fixed payment REGARDLESS of what the healthcare organization charges. Other large health insurance companies that we do have contracts with have implemented white bagging outside of the normal contracting process by unilaterally implementing a national policy and therefore require the patient to seek their medications outside the normal process.
Secondly, I would like to briefly discuss the experience that a patient faces when it comes the financial obligation related to the administration and cost of medication for these services. I will share with you several examples that our front line and business office people experience when interacting with patients who are forced to use white bagging.

- Here are three common examples in which a patient and family have to pay for a medication they have not yet received, and may never receive, under the white bagging process. This happens because the patient has to pay the third party pharmacy before that pharmacy will dispense the drug and send it to us.
    - When the patient's condition changes (for example, their weight changes), they can no longer receive the drug that they already paid for. In our normal process, we can control the medication inventory and would not bill for those services.
    - Unfortunately, if a patient passes away before the medication can be administered – they have already paid for it in advance. The family cannot recover those costs, which can be hundreds of dollars (is that right?) In our normal process on the other hand, , because we would have controlled the medication inventory, the patient nor the family would have been billed.
    - When the patient's dose needs to be increased per the physician—but this is not recognized until the patient arrives. In the situation the patient would have to start the ordering process over and return a different day for treatment. In our normal process, we can and do make the adjustment at the time the patient arrives as we have the medication on hand and can safely administer the correct dose.

- Since white-bagging coming out of the patient's pharmacy benefits the health system who may infuse the drug are unable to assist in providing financial assistance as they have to pay the third-party pharmacy the copayment up front before the drug can be sent to the provider. Therefore, we cannot provide any community/charity care options, etc. – this happens a lot and in many instances we can save the patient and family a significant amount of money due to financial aid options as well as charity care. In addition most often if someone has financial issues, the typical advise from a bankruptcy attorney is to not pay your medical bills

- And one final patient example: We have a patient that receives her infusions at one of our rural sites in Marinette, and travels an hour to get to her infusion. She is unable to drive and therefore relies on scheduling a transport company for her infusion days. This patient is

required to call the insurance's specialty pharmacy and order her drug prior to her appointment and then call the infusion center's pharmacy to let them know it should be on its way. The infusion center's pharmacy in Marinette then tries to closely monitor the arrival of this medication. If the drug has not arrived by the day prior to appointment, this patient has to cancel her transportation or she will have to pay for that transport cost if it is less than 24 hour notice on cancellation. The logistical expectations put on patients and health systems is extreme and difficult to sustain for one patient, let alone multiple patients, all on different medications, different insurances/specialty pharmacies, different rules, different social living situations, etc.

We respectfully ask that you support this important piece of legislation to ensure that patients should expect that they can get accessible care including very important medications when a provider is contracted in their network.

Thank you very much for your time.

Respectfully submitted,

James A Dietsche
Executive Vice President-Chief Financial Officer
Bellin Health

Marshfield Clinic
Health System

1000 North Oak Avenue
Marshfield, WI 54449

TO: Members of the Assembly Committee on Health

FROM: Sarah Rall, PharmD, Core Line Administrator, Pharmacy, Marshfield Clinic Health System

DATE: February 16, 2022

RE: Support Assembly Bill 718 – Protecting Patients from Mandated Insurance Practices

Chairman Sanfelippo and members of the Assembly Committee on Health, thank you for allowing us the opportunity to testify today in support of Assembly Bill 718, Koreen's Law.

My name is Sarah Rall and I have been a pharmacist in Wisconsin for over twenty years. Throughout my whole practice I have worked with patients to receive the medications that they need: when they need it, where they need it, and in a matter that works for them. Since I started my career I have watched the amount of medications that are administered in hospitals or physician offices save lives and improve care. We have made tremendous strides in providing options for patients with serious or life threatening diseases. With this advancement has come increases in cost.

In my role it is my responsibility to ensure that my patients receive the most cost effective medication treatment possible. I advocate strongly for patients to lower health care costs as health care costs directly impact the communities we live in. I am coming to you today to urge to vote for Koreen's law as I believe that "White Bagging" is not the best option for my patients.

At Marshfield Clinic we do not allow white/brown bagging in our facilities. We made this decision many years ago as we saw the risks to our patients being too high. This was for a variety of reasons including medications arriving frozen or in coolers no longer maintaining temperature and being too warm. Also, in some cases they did not match the patients' needs due to dose adjustments, arriving too late, and the need to pay a specialty pharmacy out of pocket prior to obtaining the medication.

Marshfield Clinic has worked to negotiate our agreements with insurance companies to prevent white bagging or brown bagging being required. We are however now seeing that insurance companies are changing patient out of pocket expenses, outside of the contract, to push the patients towards white bagging when there was a good faith

negotiation with the insurance company to provide these services at a rate that was agreeable to both parties.

In the current environment in central and northern Wisconsin we have experienced many shipping delays with our medication shipments using the large logistics companies. Lately it is routine that shipments do not arrive on time and we have turned the package away and obtained a new supply because it was outside of temperature range. The pharmacy has sufficient inventory on hand so that when this occurs we do not have to delay patient care as we have other products that can be used. When medications are white bagged this is not an option and the patient's treatment will need to be delayed. This is a last minute change in treatment which means that the patient has likely taken off work, arranged transportation, child care, etc all of which will now have to be arranged for another day.

For these reasons I urge you to vote yes for Koreen's bill. Thank you.

bellinhealth

Official Healthcare Partner of the Green Bay Packers

Testimony before the Assembly Committee on Health
2022 Assembly Bill 718 – "Koreen's Law"
February 16, 2022

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

Chairman Sanfelippo and members of the Assembly Committee on Health, thank you for providing the opportunity to testify today in support of Assembly Bill 718. 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 importance standardization 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 serious 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

Assembly Bill 718
Wisconsin Assembly Committee on Health
AHIP Testimony

Thank you for the opportunity to speak before you today. My name is Miranda Motter, and I am the Senior Vice President for State Affairs and Policy for AHIP, the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans, including to many patients, families, and employers in Wisconsin. We are committed to market-based solutions and public-private partnerships to make health care better, and to make coverage more affordable and accessible to everyone.

Today, I am here to speak about our work to fight for more affordable medications and specifically about our objections to Assembly Bill 718. **Simply put, Assembly Bill 718 will create a statutory monopoly on physician-administered drugs to hospital-owned pharmacies, leaving patients, families, and employers in Wisconsin exposed to out-of-control specialty drug prices and excessive physician markups. Together this will undermine affordability and access to care and coverage for the people of Wisconsin.**

Specialty drug prices are high and growing. Everyone should be able to get their prescription drugs at a cost they can afford. Hardworking families should have not to choose between affordable medications and their daily living costs. Health insurance providers are fighting for patients, families, and employers for more affordable medications, and this work is particularly critical when it comes to specialty drugs. Specialty drugs generally are high priced medications that treat complex, chronic, or rare conditions and can have special handling and/or administration requirements. Both the number and the price of specialty drugs have rapidly increased in recent years and, as a result, specialty drugs are a leading contributor of drug spending growth.

- Specialty drug share of net spending across institutional and retail settings has grown from 27% in 2010 to 53% in 2020.[1]
- Average annual gross spending and average total net retail spending on retail specialty drugs more than doubled from $61.1B in 2010-11 to $157.3B in 2016-17, respectively, and $49.6B in 2010-11 to 112.6 B in 2016-17, respectively.[2]
- Growth in future years will be driven by the number of newly launched drug, which are expected to occur at higher levels than in past years with an average of 50-55 new medications launching over the next year 5 years.[3]

Physician markups on specialty/clinician-administered drugs are excessive. Patients, families, and employers are exposed to not only the high price of specialty drugs, but they are

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[1] https://www.iqvia.com/insights/the-iqvia-institute/reports/the-use-of-medicines-in-the-us#:~:text=Specialty%20share%20of%20net%20spending,slowed%20due%20to%20patent%20expiries.

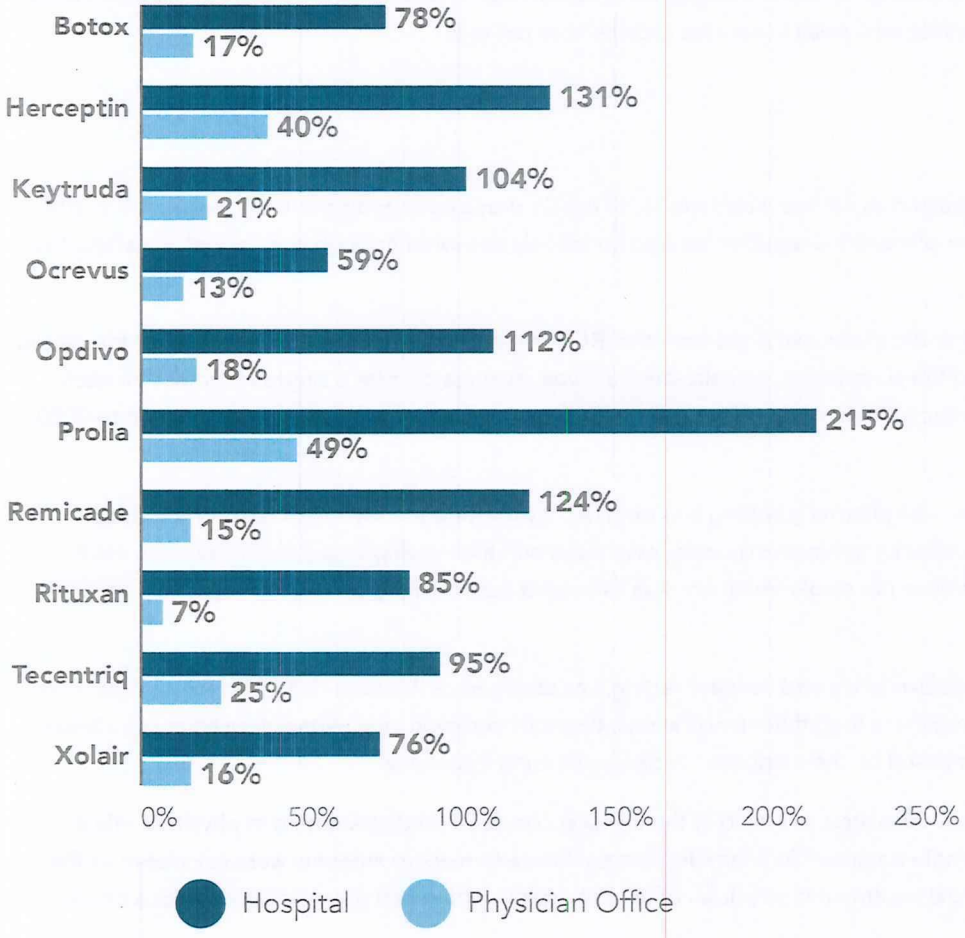
[2] https://www.uspharmacist.com/article/net-spending-on-specialty-pharmaceuticals-surging

[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.

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

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

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



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

$7,000

Costs per single treatment for drugs administered in hospitals (2018-2020) were an average of $7,000 more than those purchased through pharmacies. Drugs administered in physician offices were an average of $1,400 higher.

108%

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

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

FEBRUARY 2022

AHIP
Guiding Greater Health

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

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

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

Innovative Solutions to Keep Drugs Affordable

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

Methodology

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

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

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

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

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

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

Date: February 16, 2022

To: Members of the Assembly Committee on Health

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

Re: Assembly Bill 718 – Oppose

We would like to thank Chairman Sanfelippo and members of the Assembly Committee on Health for the opportunity to speak today about Anthem's concerns regarding AB 718, 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.

At the Senate hearing on January 20th, we heard testimony from providers who indicated they are not aware of the exceptions process. While information about this process has been shared with all of our providers since this initiative began in July 2021, we wanted to ensure that everyone was on the same page. Over the last three weeks, our Wisconsin team has reached out and connected with each provider currently using CVS Pharmacy to again explain the process and provide a copy of our exception form. Our health care providers are vital partners in our goal of building healthier lives and communities in Wisconsin. We deeply value that partnership and we remain committed to open communication toward that purpose.

Anthem's Concerns with AB 718

Because of the reasons above, Anthem must oppose AB 718. 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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Good afternoon Chairman Sanfelippo and committee members. 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. I chose a career in nursing and cancer care to help people during one of the most frightening times in their lives. I met Koreen and Nate just over a year ago. I am so happy to be here with them today, 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. This bill is the first time I have ever advocated for patients at the state level. I am here because this issue is so important.

A cancer diagnosis is extremely stressful for patients and their families. For this reason, 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. They create confusion, frustration, fear, and worry. These policies can lead to patients missing, delaying, or forgoing treatment all together. We are talking about treatment that is often **life-saving**.

White bagging policies are prone to a host of problems including shipping delays, delivery errors, and no good way to mitigate for patient-specific factors. Typically, these medications are mixed "just-in-time" on the day of treatment to allow for dosing adjustments related to changes in a patient's weight or condition. 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 prevent the hospital from being able to ensure the medications have been handled and stored properly, and make real-time dose adjustments difficult and likely, wasteful.

White bagging policies can also lead to delays in treatment. Delays result in sub-optimal care and outcomes, and also add to the stress and fear of patients wondering if a delay will cause their cancer to grow, spread, or come back. The

tears and frustration are very real. The hours spent trying to understand what is happening and why are exhausting. Imagine, as a patient, hearing that, even though you are seeing an **in-network** provider, *and* the treatment plan is **approved**, you cannot receive the life-saving medication with your provider of choice, the provider you have come to trust with your life. Imagine hearing that although most of the medications in your treatment plan are covered by your medical benefit, this one particular medication is not, and must go through the pharmacy benefit. Imagine the specialty pharmacy withholding delivery of the medication if you cannot afford, up front, your co-pay for the medication. Imagine calling the insurance company for clarification and having the representatives not understand what white bagging is, and therefore they cannot answer your questions. Imagine trying to understand all of this when you have just been told you have cancer. These are real consequences that have happened to real people. It is easy to see how patient outcomes and quality of life are negatively affected by white bagging policies. For Koreen, days were spent by Koreen, Nate, myself, and several other staff trying to appeal the insurance company's new policy.

Unfortunately, Koreen is not alone. White bagging policies have affected numerous other patients I have cared for like John with lymphoma, Yvonne with lung cancer, and Jocelyn with breast cancer. Some have had to transfer their care, struggle through the lengthy appeal process, or choose not to receive the recommended treatment and select second options instead.

For these policies to impact even one patient, it is too many. Please support Assembly Bill 718 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, allow this practice.

Our team is there to provide excellent care, our hospital pharmacy is integrated with our cancer center and the medications are on the shelf. 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 creating undue stress and risking positive outcomes for our patients.

Quartz

TO: **Members of the Assembly Committee on Health**

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

DATE: **2/16/2022**

RE: **Written Testimony Opposing Assembly Bill 718 – Prohibiting certain practices relating to insurance coverage of clinician-administered drugs**

Chairman Sanfelippo, Vice-Chair Summerfield and members Assembly Committee on Health:

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 Assembly Bill 718. 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 AB 718 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 in-person 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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Wisconsin Association of Health Plans

Assembly Bill 718
Assembly Committee on Health
February 16, 2022

Chair Sanfelippo, 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 Assembly Bill 718 because the legislation removes nearly every existing tool health insurance providers have to encourage more affordable, 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 fight 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 to make a rapidly growing class of high-cost specialty drugs more affordable? 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 an even 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 timely, safe 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.

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Ryan T. Rice
Principal & Practice Lead
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February 16, 2022

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

To Whom It May Concern:

Chairman Sanfelippo, and distinguished members of the Assembly Health Committee, my name is Ryan Rice, Principal and Practice Lead of The Prism Health Group (Prism). 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.

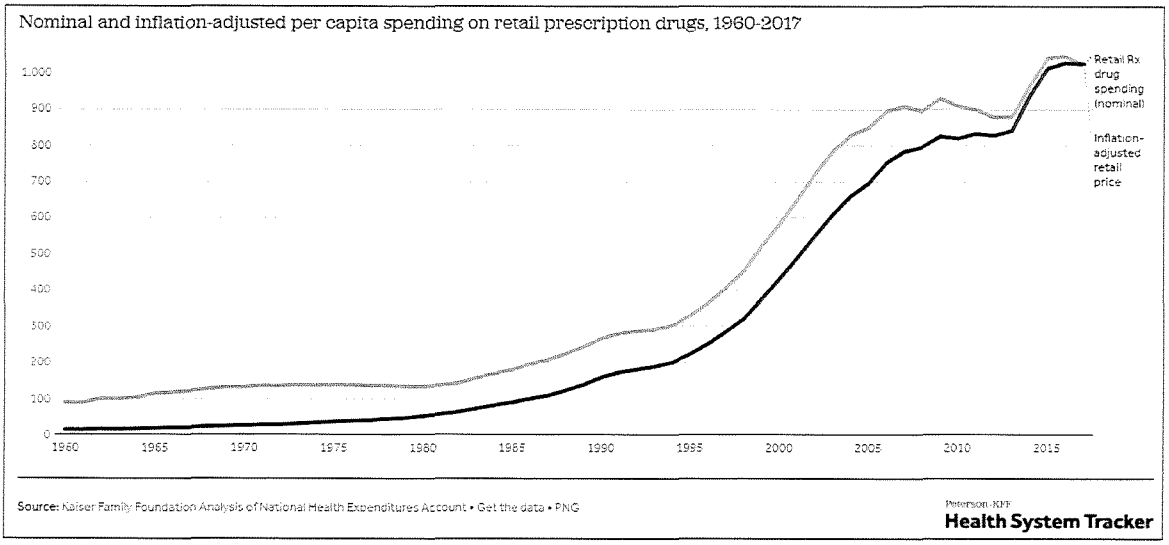
Several medications that AB 718 / SB 753 would impact are also eligible for 340B pricing. The 340B program also allows payors and Covered Entities to purchase the eligible drugs for literal pennies on the dollar, yet resell the drug to patients that have traditional insurance coverage through a carrier 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.

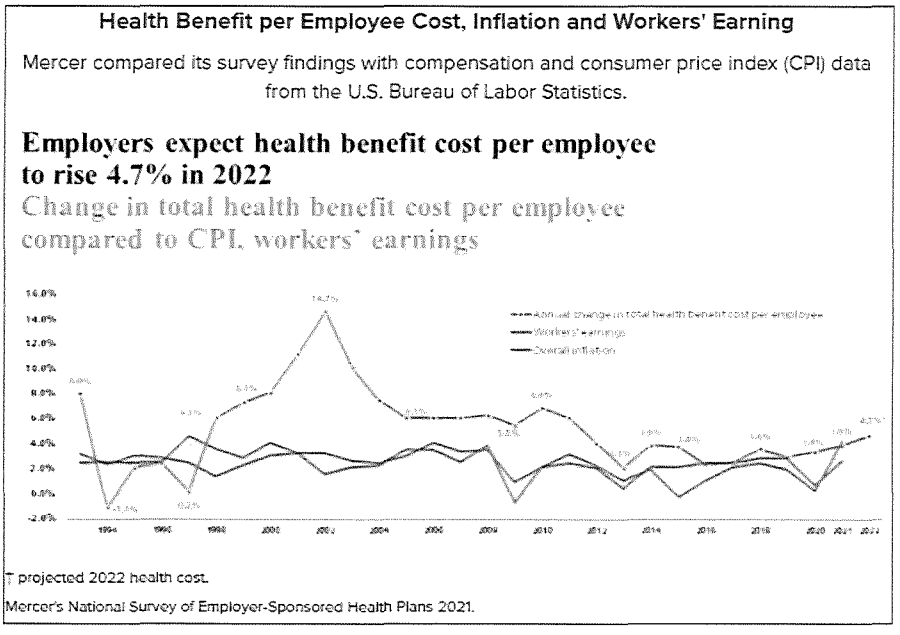
A report published by The Peterson Center on Healthcare and Kaiser Family Foundation (KFF), a partnership that monitors the United States healthcare system quality and cost, showcases an analysis of National Health Expenditures Account data reporting that on a per capita basis, inflation-adjusted retail 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.

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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
Principal & Practice Lead
The Prism Health Group, LLC

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https://wustl.app.box.com/s/wpqr6704f02eywivqsz7h1vfn8seb848

https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/health-plan-cost-increases-return-to-pre-pandemic-levels.aspx

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

END

COMMON GROUND

HEALTHCARE COOPERATIVE

Written Testimony Opposing Assembly Bill 718 Relating to Clinician-Administered Medications

Assembly Committee on Health
February 16, 2022

Chairman Sanfelippo and members of the committee, we appreciate the opportunity to submit written testimony regarding Assembly Bill 718, 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 AB 718

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 AB 718 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 718 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.

Testimony Opposing AB 718

Relating to Clinician-Administered Medications

Megan Zimmerman, Vice President-Marsh McLennan Agency

February 16, 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.

The employers I work with know that the heart and success of great companies are their employees and their workplace culture. That's why they hire me, to help them take care of their workers and their families which are their most important asset.

Next to salary, health insurance is the most expensive benefit employers provide. It's also the benefit most valued by job seekers. Unfortunately, it is more expensive for employers to provide health benefits in Wisconsin than it is in Iowa, Michigan, and Illinois. Making matters worse, pharmacy cost trend in Wisconsin is right now outpacing medical cost trend. The kinds of specialty medications we are discussing today often account for 50% or more of the entire pharmacy spend we're seeing.

To mitigate cost and get employees access to the affordable health care they need, programs such as safe "white bagging" are essential to protect the financial well-being of employees. Safe "white bagging" saves money for employees, and using this tool enables many employers to offer full coverage of these medications.

I know we have heard stories today about difficulties some patients have experienced. I can tell you that none of the employees I work with have experienced this, and I would be the first person they would call. The process has worked smoothly and employees are thrilled to have access to needed medications that cost them very little and are delivered safely through strict safety protocols.

On the other hand, costs will increase if you ban white bagging and some of that increase will inevitably fall to employees who cannot afford it. You've heard today that medical costs are a top concern for employers. This is also true for employees. Medical costs are the number one cause of bankruptcy today, and one out of every six Americans have an unpaid medical bill on

their credit report.[3] Right here in Wisconsin, hospital lawsuits over unpaid medical bills went up by 37% between 2001-2018.[4] This is literally bankrupting hard working families.

These are the kinds of difficult stories I hear all the time, about people avoiding care because of cost. So as you listen to patient stories today, please know there is another side to this issue that is equally heart breaking for many Wisconsin families.[5] According to researchers at Johns Hopkins, about half of our federal tax dollars today are going to pay for medical care, and then consumers are asked to pay even more when they themselves need care.[6] I would call this "Taxation without Representation" and it's at a level now that is simply not sustainable.

The easiest way for the Wisconsin legislature to help reduce the high cost of healthcare care is to increase competition. That's what white bagging does – it creates competition for hospital pharmacies to help drive down the prices and the markups they are charging. It's safe, reliable and the employees I work with have had only good experiences.

In closing, I just want to remind you that employers as health plan sponsors have a fiduciary responsibility to examine and document the financial quality controls they have in place relating to cost, coverage, quality, expense for the medical and pharmacy benefits. When hospitals are pricing medications well above the market rate, employers would be remiss from a fiduciary perspective if they didn't consider alternative sourcing.

With all this in mind, I strongly encourage this body to consider the dramatic financial ramifications this bill's passage would have on employers and employees here in Wisconsin. The heart and success of our business community and the families they support simply cannot afford it.

Thank you for the time. Please feel free to reach out to me with any questions:
megan.zimmerman@marshmma.com or 414-795-6974

[3] Americans' Challenges with Health Care Costs | KFF
[4] Hospital Lawsuits Over Unpaid Bills Increased By 37 Percent In Wisconsin From 2001 To 2018 (Health Affairs)
[5] In 2018, The Average Family Paid More To Hospitals Than To The Federal Government In Taxes (forbes.com)
[6] We spend about half of our federal tax dollars on health care. That's ridiculous. (USA Today)

Thank you, Mr. Chair and members of the committee. I'm Pat Blackaller and I am the Director of Finance and Operations for the Rice Lake Area School District. I will be speaking in opposition to AB718.

The Rice Lake Area School District changed its approach to healthcare for 2017. Why--- because our district could not afford the cost of healthcare without drastically diminishing educational services provided to children. We found a better, more cost-effective way to provide healthcare to our staff. It is our obligation as public servants to spend public dollars wisely; tax dollars should benefit children directly, rather than health systems.

And now for some statistics:

1. For the 2017-2018 plan year, our overall health plan costs would have been $5.1 million with pharmaceutical costing $750,000.

2. 5 years later, we are projecting $3.4 million in total plan costs and only $250,000 for pharmaceuticals. This is a three-fold decrease in pharmaceutical costs, and a $1.7 million decrease in overall plan costs, even with 5 years of medical inflation.

We have saved over $10 million in medical costs over 4.5-years.

How did we save so much while providing better benefits at a lower cost?

1. We are using free market principles to deliver the highest quality care available.
2. Our employees are now consumers of healthcare rather than passive recipients.
3. The school district directly contracts with providers.
4. Our plan provides access to needed pharmaceuticals from cost competitive sources that are ethically and safely sourced.

Our rural district competes for talent against larger urban school districts in communities with lower healthcare costs. We live in probably the most expensive healthcare market in the nation (northwest Wisconsin). This puts us at a competitive disadvantage. We have to do more to reduce costs while providing high quality benefits. If we do not, our students will pay the price. We have been crippled by exorbitant healthcare costs and pharmaceuticals play a central role in these costs.

If a service station was given exclusive control of the gasoline supplies in a region, do you think the fuel prices in that region would be competitive priced? AB718 is giving medical systems monopolistic control over a portion of the pharmaceutical supply chain.

Example:

An employee was directed by their "system doctor" to get an infusion. That infusion was going to cost $29,000 in the hospital. Our health plan had a no cost option for the employee at an alternative location to get that same medication from the same pharmaceutical company for $13,000. Why does the same exact medication, provided in the same way cost $16,000 more in a system? This bill would canonize that type of abuse.

Passage of this bill will cost our plan and taxpayers hundreds of thousands of dollars. We will simply have to cut staff and reduce services to children.

This is couched under the guise of safe and timely sourcing of medications. We have never had a case in which mediations were delayed or sourced inappropriately through this process. The reality is, the hospital systems want control of a revenue stream. This is a major profit center for health systems. We want our staff to get high quality care quickly and at a fair price. We currently have that ability. This bill would change that dramatically.

We want our staff to get high quality care quickly and at a fair price. We currently have that ability. I urge you not to take these types of tools away from us.

Thank you for your time, I would be happy to answer any questions.

The Alliance
Self-Funding Smart®

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

Cheryl DeMars, President and CEO – The Alliance

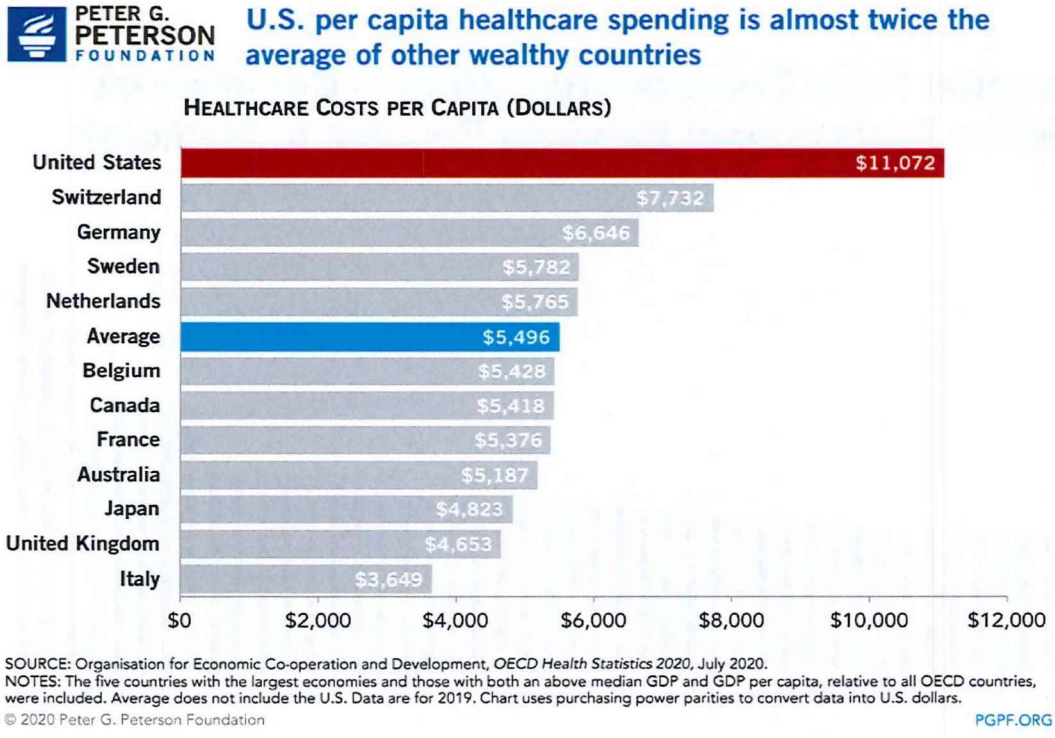
Assembly Health Committee

February 15, 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.

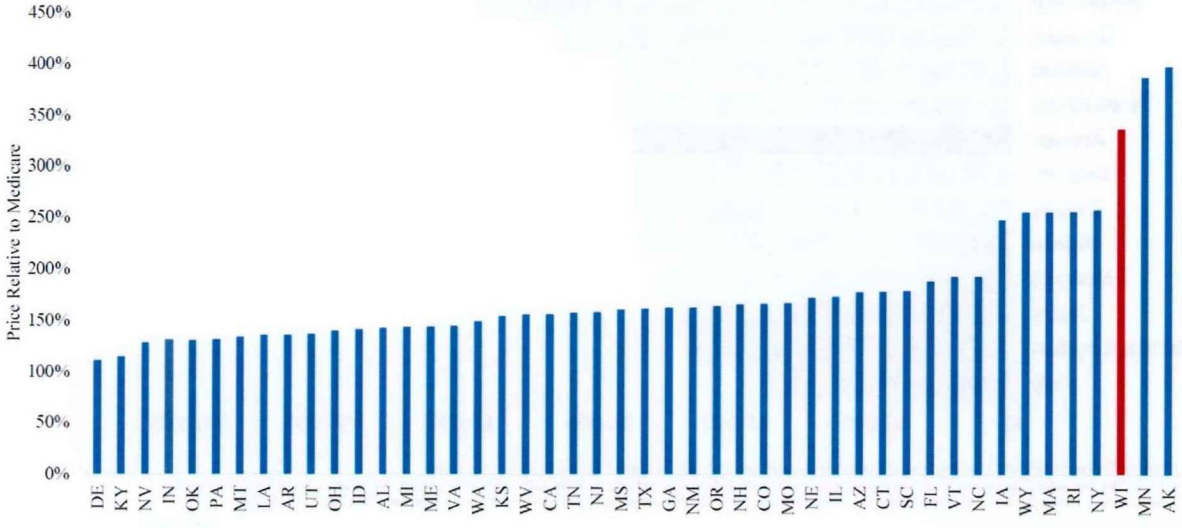


What's more, in Wisconsin, prices for the commercial market (non-Medicare and Medicaid) are abnormally high compared to other parts of the country. According to the most recent data from the RAND Corporation, we are tenth in the country in terms of hospital prices, and we pay the third highest physician 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
The Alliance
PO Box 44365
Madison, WI 53744

cdemars@the-alliance.org
(608) 210-6621

Testimony Opposing Assembly Bill 718, Relating to Clinician-Administered Medications

Sara Hames, NBS Advisors, LLC
Assembly Committee on Health
February 16, 2022

My name is Sara Hames and my job for decades has been to help employers, especially self-funded employers who essentially pay their own claims, manage their health benefit costs. I'm sorry to say that while employers keeping working to successfully tackle costs in their benefit plans, health care is still unaffordable for many employers and employees simply because health care prices continue to outpace everything else.

Alternative sourcing of medications which includes 'white-bagging' has been an important, safe strategy that's proven to be cost-effective and therapeutically beneficial to both employers and their members. The process also exposes the egregious price-gouging that occurs when hospitals source their own medications, which hospitals have tried to keep hidden by not disclosing the prices they actually pay for these medications.

For example, a review of claims paid for one Wisconsin employer revealed a simple injectable drug that retails for $600 cost this employer $6000 per dose, a mark-up of 1000%. There were 16 claims billed by this Wisconsin hospital. The self-funded employer paid $96,000 in total when they should have paid $9,600. How is that fair to employers? More importantly, why would the legislature want to keep employers from using free market competition to address this problem?

Another employer saved 49% of its prescription drug spend in just one year by alternative sourcing allowing them to give lower cost medications to all of their members.

A Wisconsin school district covering 400 employees is currently on track to save over $700,000 this year alone through safe, alternative sourcing of prescriptions. Members are thrilled to get the medications they need at low or no cost to them without comprising safety. And imagine what a school district can do with an extra $700,000: hire 7 new teachers, add more mental health resources, fix crumbling buildings, etc.

Even with federal rules and regulations around transparency, health care pricing especially from hospitals is almost completely opaque in Wisconsin. Unlike any other product or service we purchase as consumers, finding the price of a health care service through a hospital is like finding a needle in a haystack. Even I as a consultant don't have access to enough good data.

Take away free enterprise tools like alternative sourcing and the only choices left for employers are to stop covering expensive treatments or move to another state where health care is significantly cheaper, like Michigan where they spend an average of $2,000 less per employee per year on health care.

But when employers think about different ways to deliver better health care and they can use free market innovations to do so, costs go down and care improves, a win-win for Wisconsin employers and their workers.

Thank you,

Sara Hames, CEBS
Principal, NBS Advisors, LLC (sara.hames13@outlook.com)
414.374.3805

NBS
Advisors

February 16, 2022

TO: **Members**
Assembly Committee on Health

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

RE: **2021 Assembly Bill (AB) 718 relating to: prohibiting certain practices relating to insurance coverage of clinician-administered drug**

Chairman Sanfelippo and committee members my name is Brian Dake, President of Wisconsin Independent Businesses. Thank you for the opportunity to testify in opposition to 2021 Assembly Bill (AB) 718.

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 – 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.

When it comes to health care coverage for themselves and their employees, most Wisconsin small business owners find themselves between a rock and a hard place. They do not have the financial wherewithal to self-insure. Instead, they must purchase more expensive coverage plans available in the individual and small group market. Small employers who cannot offer affordable health care coverage to their workers have difficulty retaining their valued employees and struggle to hire highly qualified, experienced, and well-trained workers. If enacted, AB 718 would keep many Wisconsin small business owners in this unenviable position.

WIB GROUP HEALTH PLAN

PARTNERSHIP & AHP OFFER

- NEW - EASIER TO QUOTE!

Wisconsin Independent Businesses (WIB) in partnership with 5G Benefits, LLC, a Wisconsin-based insurance agency, have an exclusive Group Health Plan Partnership to benefit all WIB members.

Along with promoting an exclusive WIB Affinity Health Plan (AHP), 5G Benefits is also an independent agent, and will review all options available in the industry, including individual, medicare, fully insured, level funded and self-funded plans. 5G Benefits will be able to quote dozens of carriers to find the best option for your business, employees, and family.

WIB members who work with 5G Benefits as their health insurance agent receive exclusive benefits including compliance services (Section 125 plan/ERISA Wrap document), HR Hotline access (team of HR consultants at no charge), HR technology help, benefit package creation, and expert local advice and education.

continued on back

WIB MEMBERS ARE SAVING!

Menomonie, WI company
SAVED 24%!

$2500 deductible with 100% coinsurance (Copay plan)

Single: $456.11/mth
Family: $1,336.40/mth
Emp/Spouse: $935.02/mth
Emp/Children: $875.73/mth

Washburn, WI company
SAVED 36%!

$5000 deductible with 100% coinsurance (HSA Qualified Plan)

Single: $352.06/mth
Family: $969.02/mth
Emp/Spouse: $853.54/mth
Emp/Children: $969.02/mth

"The program offered through 5G Benefits with WIB provided nearly a 25% savings. 5G Benefits' custom service and attention to small business needs is exemplary."

WIB
Wisconsin Independent Businesses

WIB GROUP HEALTH PLAN PARTNERSHIP & AHP OFFER

ANOTHER WIB MEMBER COST-SAVING BENEFIT

The WIB AHP and the carriers 5G Benefits offers has most hospitals/doctors in the network in Wisconsin. There is also national coverage for employees traveling or living outside the area using a wrap network. 5G Benefits is an independent agent and will help to choose which network and carrier best fits your group, based on your location. There are also exclusive plans offered only through 5G Benefits that WIB members will be able to access!

NOTABLE INSURANCE CARRIERS* OFFERED BY 5G BENEFITS IN WISCONSIN:

- Lifestyle Health Plan / Medova (Affinity Health Plan partnership with WIB)
- Aetna
- The Alliance
- All Savers
- Anthem
- Aspirus Arise
- Auxiant
- Christian Care Plans
- Commonground
- Dean Health
- Group Health Cooperative
- Humana
- Molina
- National General
- Network Health
- Prairie States
- Prevea360
- Quartz
- Robin Health Partners
- Security Health
- Starmark
- Trilogy
- Together with Children's
- UMR
- WPS

If you currently have one of these carriers, 5G Benefits can take over as the existing agent and you will immediately receive all the exclusive WIB value adds! Or reach out today and 5G Benefits can quote every carrier and the exclusive WIB AHP to try to find savings and a better plan.

NOTABLE HOSPITALS IN THE NETWORKS AVAILABLE INCLUDE:

- Agnesian
- Ascension/ Ministry
- Aspirus
- Aurora
- Bellin
- Black River Memorial
- Children's
- Columbia
- Columbus Community
- Cumberland
- Dean/SSM clinics
- Divine Savior
- Edgerton
- Flambeau
- Froedtert
- Gunderson
- Holy Family
- Marshfield
- Mayo
- Meriter
- OakLeaf
- ProHealth
- Prevea/HSHS
- Sacred Heart
- St. Elizabeth's
- St. Mary's
- Sauk Prairie
- ThedaCare
- Waukesha Memorial
- UW System

and so many more!

DENTAL, VISION, DISABILITY, LIFE AND VOLUNTARY PLANS ARE AVAILABLE:

5G Benefits can provide dozens of options to build a great benefit package. Including Delta Dental, Aetna Dental, Metlife, Principal, Colonial, Assurity, Guardian, Eye Med, VSP, Superior, EPIC, Pekin Life, Ameritas, Hartford, UNUM, and dozens of other carriers! You do not have to take the medical option to have 5G Benefits look at voluntary options.

* 5G Benefits is directly contracted with these carriers and there is no relationship to WIB.

FOR A QUOTE:

WIB members work directly with 5G Benefits, LLC to obtain coverage but can get forms to quote by visiting **www.wibiz.org**

Complete:

- WIB Group Benefits Quote form
- 5G/WIB Census Form

Submit information to:

- WIB@5GBenefits.com or fax 920-227-2247

You will receive a call within 48 hours and a quote within about 2 weeks, a little longer during fourth quarter.

QUESTIONS:

Please email Tony Goebel / 5G Benefits at WIB@5GBenefits.com.

5G Benefits GOEBEL Insurance

5G Benefits, LLC is the licensed insurance agent for all policies written through the WIB Health Plan Partnership. WIB is not a licensed insurance agency and its sales representatives are not licensed insurance agents.

WIB Wisconsin Independent Businesses

wibiz.org

AHI
ALLIANCE OF
HEALTH INSURERS

To: Chairperson Joe Sanfelippo
Members, Assembly Committee on Health
From: R.J. Pirlot, Executive Director
Rebecca Hogan
Re: Opposition to AB 718, 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 Assembly Bill 718 and appreciate the opportunity to share these concerns with the Assembly Committee on Health.

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.

AB 718 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, AB 718 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, AB 718 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. AB 718 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. AB 718 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 AB 718 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 Assembly Bill 718 for the reasons shared here.

Eliminating White Bagging in Wisconsin Will Cost the State Almost $2.1 Billion In Increased Drug Costs

Legislation that would bar health insurers from implementing a pharmacy policy known as "white bagging" will seriously undermine the ability of health plans and PBMs to manage their medical specialty pharmacy expenditures, and as a result, drug spending in Wisconsin would soar. Restricting white bagging in Wisconsin could cost the state $166 million in excess drug spending in the first year alone, and $2.1 billion over the next 10 years.

What is "white bagging"?

White bagging allows for a drug to be shipped directly to a patient's health care provider, where it is administered to the patient, from their specialty pharmacy. Claims processing for the drug happens in real time through the drug benefit rather than through the medical benefit, where physician "buy and bill" can lead to payment delays and high costs. The health plan sponsor then reimburses the specialty pharmacy for the ingredient cost of the drug, and sometimes a dispensing fee, and reimburses the provider for the cost of the drug's administration. The cost of these drugs through specialty pharmacies is typically lower than through providers. Use of white bagging has real benefits for patients, providers, and health plan sponsors.

Benefits of White Bagging

For employers, states, federal government, and other health plan sponsors

- **White bagging often is much less costly:** There are meaningful savings for employers, other health plan sponsors, and government health care payers when physician-administered prescription drugs are dispensed through a specialty pharmacy instead of a hospital or provider office that buys the drug and then marks it up, a practice known as "buy and bill."
- **If the current use of white bagging in Wisconsin was eliminated, then costs to the state's health system could reach $2.1 billion over the next 10 years.**

For patients

- **Improved access to care:** "[W]hite bagging can improve access for patients, particularly for patients receiving care with small providers."[1] Patients with physicians who are unable to source, afford to buy, and then store a medication can receive convenient care when a white-bagged medication is delivered to the office just ahead of a visit.
- **Improved affordability and transparency:** Through white bagging, a physician-administered prescription can be covered under the pharmacy benefit, which may have lower patient cost sharing than the medical benefit usually used for physician-administered drugs. In addition, the pharmacy benefit processes the claim in real time, which supports patient awareness of their cost sharing.

For health care providers

- **Real-time claims billing:** Unlike the medical claims process, pharmacy benefit claims processing is handled in real time so that authorization and patient cost sharing are processed upfront. Health care providers know their fees, and claims are typically quickly paid.
- **Temperature Controlled Packaging:** Special white bagged packaging obviates receiving and carefully storing certain drugs prior to administration. White bagging also may support smaller health care providers' treatment of patients without the need to coordinate through a hospital or other outpatient facility.
- **Direct communication with provider:** The specialty pharmacy confirms patient and prescription information for shipping and requires signature upon delivery. Real time changes in dosage amounts are addressed directly with the provider to prevent patient delay in treatment and to mitigate waste. Physician-administered drugs dispensed by a specialty pharmacy usually are for maintenance medications, where dosing is well established and changes in dosing are uncommon.

Projected 10-Year Increases in Drug Spending In Wisconsin, 2022–2031 (millions)

	Self-Insured Group Market	Fully Insured Group Market	Individual Direct Purchase	Medicaid	Total
White Bagging Restrictions	$875	$682	$146	$364	**$2,068**

Methodology: The methodology used to create these cost projections is described in the October 2021 paper "Benefits of White Bagging Dispensing."

[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.

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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

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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).

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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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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.