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AHIP is a national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, businesses, communities, and the nation. Americans deserve access to comprehensive, quality, affordable coverage. AHIP is committed to advancing policy solutions in support of these goals.

As an advocacy organization committed to market-based solutions that make access to high-quality healthcare affordable, I thank you for this opportunity to share our serious concerns with Senate File 482.

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

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

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

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

Notably, the “specialty drug” share of net spending across institutional and retail settings has grown from 27% in 2010 to 53% in 2020[3] according to recent study from the drug data firm IQVIA. Further, this study notes “growth will be driven by adoption of newly launched innovative products, which are expected to occur at higher levels than in past years with an average of 50-55 new medicines launching per year over the next five years, including those in oncology or with specialty or orphan status.”[4] To put this in dollar terms, another study found “average annual gross spending and average total net retail spending on retail

specialty drugs more than doubled from $61.1 billion in 2010-11 to $157.3 billion in 2016-17, respectively, and $49.6 billion in 2010-11 to $112.6 billion in 2016-17, respectively.[5]"

Many specialty drugs are administered by a clinician intravenously, intramuscularly, under the skin, or via injection. These specialty drugs are given at a variety of sites of care including hospitals, medical provider offices, infusion centers, and by medical professionals during home visits. But where do clinicians get these drugs to administer to their patients?

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

Moreover, specialty pharmacies typically ship their products directly to clinicians just like a manufacturer or wholesaler would, but also—when safe and appropriate—to patients. Specialty pharmacies must also abide by all state and federal legal and regulatory requirements, including chain of custody (pedigree) tracking in addition to meeting extra safety requirements for specialty drugs imposed by the Food and Drug Administration (FDA) and drug manufacturers. Specialty pharmacy staff also help coordinate a patient's care by providing close monitoring, collecting data, and sharing that information between the patient's health care providers.

> **On top of providing these additional, unique services, specialty pharmacies typically provide drugs at a substantial discount as compared to those dispensed by hospitals or physician groups, which leads to cost savings for patients, families, and employers.**

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

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

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

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

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

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

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

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

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

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

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

Unfortunately, SF 482 serves only to prevent use of such tools that safely encourage lower cost, high quality care that, in turn, allows health plan sponsors to stretch their health care dollars to provide more comprehensive coverage to their enrollees. Patients and payers are taking advantage of the introduction of competition into this care setting, driven by innovations in logistics and care services pioneered by specialty pharmacies that provide opportunities to drive out waste in this drug dispensing channel without sacrificing quality of care or access to these critically important medications.

In short, this legislation cuts off at the knees any meaningful, scalable effort to control one of the most significant and fast-growing portions of patients' and employers' health care dollar. These "just in time" processes for delivering and/or dispensing specialty meds are, again, no different from the same ones used to deliver these drugs directly to the providers who would dispense them now, and if this legislation is passed. Moreover, administration of these drugs is provided in the same way regardless of setting—whether in the hospital, physician's office, independent infusion center or, where appropriate, certain retail pharmacy settings.

While we oppose SF 482 at the conceptual level, our concerns can be grouped by the following themes and this legislation's negative impacts on each: drug and service costs; patient access; patient safety and quality of care; medical necessity; market competition; fraud, waste and abuse; and freedom of contract.

Drug and Service Costs:
When it is safe and medically appropriate to do so, patients benefit from drugs being administered in the least restrictive and lowest-cost setting.

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

Medical Necessity:
SF 482 goes far beyond prohibiting the practice of white bagging and reaches deep into many of health insurance providers' core practices. Specifically, this bill overreaches by eliminating the long-established ability of insurers to define "medical necessity" in their coverage policies.

Market Competition:
Individually and collectively, the provisions of SF 482 create an anti-competitive, high-cost clinician-administered drug market in Wisconsin. If passed, this legislation effectively removes any competitive incentive for providers to offer lower prices and higher quality care because health plans would be

prohibited from using utilization management tools for these drugs and services. Plans would not be able to employ benefit design to reward patients for seeking out care at high-quality, lower-cost sites.

Freedom to Contract:

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

Conclusion:

Again, we appreciate the opportunity to share our perspective on the harmful impacts of SF 482. Clinician-administered drugs are a leading contributor to drug spending growth and only shared stakeholder responsibility will address the burden these rising costs put on patients.

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

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