PROTECT PATIENT ACCESS TO TIMELY CARE

Prohibit white-bagging requirements and protect patient choice, safety and timely care in dispensing clinician-administered drugs

DEAR HEALTH AND HUMAN SERVICES CONFERENCE COMMITTEE MEMBERS,

We, the below organizations, are writing to seek your support for white bagging choice legislation **(SF 4410, second unofficial engrossment, article 6, section 45)** which would prohibit health insurance companies from forcing patients to obtain their clinician administered medications from pharmacies affiliated with their insurer. These so-called "white bagging" policies are an increasingly common insurance company tactic that **IMPACTS PATIENT CHOICE, DELAYS PATIENT CARE, CREATES POTENTIAL SAFETY RISKS, AND NEEDLESSLY DRIVES UP OUT-OF-POCKET COSTS.**

Historically, clinician-administered medications such as those used to treat cancer, rheumatological, and neurological conditions have been covered under a patient's medical insurance benefit. Under this traditional model, a patient's health system or clinic pharmacy is responsible for procuring, preparing, and administering these medications – while also validating the integrity of the medication and maintaining chain of custody throughout the entire process. Under a "white bagging" arrangement, the patient's health care provider must order these medications through a limited choice of retail or specialty pharmacies affiliated with (and often owned by) the patient's insurer. Medications are shipped to the clinicians to be compounded by the practice or compounded off-site and shipped to the practice for infusion/administration. This process has led to incorrect and sometimes compromised medications and often leads to delays in care for our patients. If there is a delay on the specialty pharmacy's end – or if a patient's dosage needs to be adjusted on-site the day of administration to reflect the patient's needs that day – a new appointment would need to be scheduled. And because these medications have been obtained outside the clinic's routine procurement process or mixed off-site, the practice cannot guarantee the medications have been safely and properly obtained or prepared. Finally, "white bagging" is often accompanied by a switch in coverage for a patient's medication from the medical benefit to the pharmacy benefit which can increase out-of-pocket costs on the patient's end.

The legislation included in **SF 4410, second unofficial engrossment, article 6, section 45,** does not prohibit the practice of "white bagging", as this may be an appropriate option for patients and care providers, but it does prohibit mandating the practice of "which bagging" as it could have adverse effects.

We ask you, for your constituents, to support "white bagging" choice legislation to put Minnesota patients first by putting an end to dangerous forced "white bagging" tactics before they cause real and lasting harm.
Thank you,

Minnesota White Bagging Choice Coalition

SCAN QR-CODE TO LEARN MORE

- What is White-Bagging?
- How does white bagging harm patient safety?
- How does white bagging delay patient treatments?
- Advocacy support tools
- Recent news articles

MYTHS and FACTS About White Bagging Mandates

PATIENT IMPACT

MYTHS VS **FACTS**

White bagging can improve access for patients, particularly for patients receiving care with small providers.

Unfortunately, white bagging too often hinders access to care and leads to patient care delays for patients. We agree that there are rare situations where white bagging affords access that would not otherwise be possible and is why our legislation does not ban white bagging but instead makes it a patient and provider choice.

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.

White bagging may increase patient cost sharing. This has been realized for many patients who through their medical benefit had fixed visit co-pays and out of pocket maximums. Pharmacy benefits can have higher co-pays and often do not have an out-of-pocket maximum structure leading to significantly increased cost to the patient. In addition, these patients too often encounter being charged duplicate co-pays for drugs not received due to shipping errors, treatment changes, and other factors.

Does not disrupt patient care.

Safe and efficient integrated care has been a priority to ensure high quality medications are available for patients when they need them. Requiring white bagging interrupts the patient's treatment plan, introduces unnecessary risk, and interferes with the providers ability to provide the safest possible care and service to the patient.

PHYSICIAN AND HEALTH CARE PROVIDER IMPACT

Unlike the medical claims process, pharmacy benefit claims processing is handled in real time so that authorization, patient cost sharing are processed upfront, and claims are typically quickly paid.

Processing times become irrelevant when the delays to begin treatment are considered.

Special white bagged packaging obviates receiving and carefully storing certain drugs prior to administration.

Providers navigating white bagging can relay stories of white bagged medications arriving in inappropriate packaging resulting in unusable medication. The replacements of these medications, which were sent incorrectly from specialty pharmacies, are often at the cost to the patient.

Real time changes in dosage amounts are addressed directly with the provider to prevent patient delay in treatment and to mitigate waste.

When insurers mandate drugs be dispensed via third-party specialty pharmacies, it disrupts the patient experience and impairs the delivery of optimal patient care as directed by their physician. Under these arrangements, providers have no relationship with the outside pharmacy to address concerns, navigate treatment changes, or care needs. Because medications have to be ordered in advance to assure the supply is on hand when the patient is due for treatment, any changes in drug or dosage require that the specialty pharmacy ship out new supply of drug, resulting in delays to care and additional work on care teams to communicate these changes and coordinate with the external pharmacy.

Physician dispensing is just another form of self-referral and is about increasing providers' profit margin. Many providers administering specialty drugs also own pharmacies, creating a potential conflict of interest by selling drugs at overly inflated prices to their patients through their own pharmacies, which may or may not be accredited for specialty drugs.

In the past few years, the largest health insurance companies have merged with PBMs. In 2020, the top 3 pharmacy benefit managers—all affiliated with large health insurance companies—processed nearly 80% of all prescription drug claims. Many plans require their members to fill their prescriptions through the plan's affiliated pharmacy. The bill is not aimed at increasing provider profit margins; it simply prevents the health plans from steering patients to their affiliate pharmacy.

This legislation aims to take advantage of 340B pricing.

The proposed legislation was not drafted with 340B in mind and is being brought forward based on the impact of mandated white bagging on patient care, safety concerns, drug waste and higher out of pocket costs for patients. In certain circumstances, payers may try to use mandated white bagging to avoid interaction with 340B programs to increase their savings gained through rebates and profit-sharing arrangements. Notably, though, many of the coalition members supporting this legislation do not take part in 340B programs.

EMPLOYER & HEALTH PLAN SPONSORS

White bagging decreases the total cost of care

There is no credible evidence demonstrating that white bagging decreases the total cost of care. PBM's argue that they can negotiate lower drug invoice costs and higher rebates; however, there is no evidence to support this claim. In addition, if PBM's can negotiate lower costs there is no evidence that demonstrates that these cost savings are passed down to the plan sponsors or to the patients. Furthermore, White Bagging increases the amount of drug waste generated. This wasted drug comes at the expense of the plan sponsor and the patient while the clinician is burdened with the cost of disposing the medication. The specialty pharmacies dispensing the wasted drug are not at risk for these costs and generate revenue for drug dispensed, even if it is not administered.

Specialty pharmacy networks should be allowed to require the use of network specialty pharmacies for specialty drugs because the networks allow health plans and PBMs to select pharmacies that meet certain standards that ensure consumers have access to high quality drugs.

It is not a health plan or PBM's role to regulate facility safety. The Minnesota Board of Pharmacy and the Minnesota Board of Medical Practice make those determinations and set safety standards for drug dispensing and other processes.

White bagging increases price competition between specialty pharmacies and hospitals and clinics.

White Bagging decreases price competition in the market. Shifting clinician administered medications to the pharmacy benefit eliminates the ability for clinicians to negotiate drug pricing. Furthermore, vertical integration of insurer, PBM, and pharmacy eliminates effective negotiation between payer and pharmacy and allows the vertically integrated system to set their own prices and payments.

MINNESOTA PROTECTING PATIENT ACCESS TO TIMELY CARE COALITION