STATE OF WISCONSIN
Department of Employee Trust Funds
A. John Voelker
SECRETARY

Wisconsin Department
of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931
1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

Correspondence Memorandum

Date: October 22, 2021

To: Group Insurance Board

From: Tricia Sieg, Pharmacy Benefit Program Manager
Office of Strategic Health Policy

Subject: Specialty Drugs and Site of Care Report

This memo is for informational purposes. No Board action is required.

Background

In November 2019 the Group Insurance Board (Board) approved several initiatives for improving the Group Health Insurance Program (GHIP) for members and employers.

This memo serves as a progress report on the Board initiative related to specialty drugs, and the site where those specialty drugs are administered to members. This memo provides a summary of information staff has gathered from vendors, subject matter experts, literature reviews, and interest groups, as well as possible next steps. This document offers up no final answers or final resolutions to how the Board should go forward with the ever-changing marketplace of specialty drugs. Rather this memo offers courses of actions based on what mostly private sector employers are utilizing with their specialty drug programs to help spur discussion from the Board and give staff insight into what the Board would like included in the staff's next update, scheduled for May 2022.

Specialty Drug Overview

Specialty drugs, also known as specialty-tier drugs, are medications that traditionally treat complex, chronic, or rare conditions. Specialty drugs are used to treat any number of conditions, including but not limited to cancer, asthma, multiple sclerosis, and rheumatoid arthritis.

The number of specialty drugs has grown and continues to grow at an accelerated pace. In 1990, there were ten specialty drugs on the market. In 2012, that number had grown to almost 300 Food and Drug Administration (FDA) approved specialty drugs. (American Journal of Managed Care, 2013). From January 2013 through October of 2021 the FDA has approved 379 new specialty drugs. (U.S. Food & Drug Administration, 2021)

Reviewed and approved by Eileen K Mallow, Director, Office of Strategic Health Policy Electronically Signed 11/10/2021

Eileen K Mallow

Board	Mtg Date	Item #
GIB	11.17.21	5A

According to Navitus Health Solutions (Navitus), the Board's pharmacy benefit manager, a person could need a specialty drug administered anywhere from every ten days to over a year between infusions/injections. Dosages of specialty drugs vary from drug to drug. Some dosages can be standard, where everyone on the specialty drug receives the same dosage regardless of age and weight, while other drugs are very concise -- the dosage depends on the person's weight or body surface area.

Many specialty drugs are administered by a medical professional 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. A growing number of specialty drugs can be taken orally and outside the presence of a medical professional.

Specialty drugs are also typically very expensive. Medicare defines specialty-tier drugs as any drug costing at least $670 per month (United States Department of Health and Human Services, 2020). CVS Health describes specialty drugs as, "…they are expensive – the average monthly cost to payers and patients for a specialty medication is $3,000, ten times the cost for non-specialty medications." (Hoffman & Buck, 2020) According to a study published in the American Journal of Health-System Pharmacy, in 2020, $265.3 billion or 49.6% of total prescription spending was spent on specialty drugs. This was an 8.4% increase in specialty drug spending from 2019. (Tichy, et al., 2021)

A recent study examined the 2019 prices paid for by Blue Cross Blue Shield for their non-Medicare, non-Medicaid health plans for biologics, chemotherapies, infused hormonal therapies, and other infused cancer drugs administered in hospital clinics versus provider offices. The study found Blue Cross Blue Shield would have saved $1.28 billion in 2019 if the company had excluded hospital clinics from its network and had all patients receive their infusions in a provider's office. (Robinson, Whaley, & Brown, 2021)

Options to Lower Costs

To help minimize the effect high-cost specialty drugs has on payers, a variety of entities, including Anthem Blue Cross, Cigna, and UnitedHealthcare (UHC), have notified providers and hospitals that specialty drugs provided to their insured members need to come from the insurer's specialty pharmacy, not the hospital's or provider's specialty pharmacy. This practice, known as drug bagging, is a common private sector tool to try to keep specialty drug costs low.

Payers are currently using four bagging options to deliver specialty drugs:

- White bagging: A specialty pharmacy ships a patient's prescription directly to the provider, (hospital or clinic). The provider holds the product until the patient arrives for treatment. (Keck Medicine of USC, 2021)

- Brown bagging: The patient picks up a prescription at a pharmacy or has it delivered to their home which is then taken to the provider (hospital or clinic), for administration. (Keck Medicine of USC, 2021)
- Clear bagging: A provider's internal specialty pharmacy dispenses the patient's prescription and transports the product to the location of drug administration. (Keck Medicine of USC, 2021)
- Blue bagging: A four-step, pharmacist-driven all medication review that involves working with medical providers. (Chand, Ramesh, Sah Sujit, & Kala Bahadur, 2019)

In addition to bagging options, various payers have taken some injection/infusion of some specialty drugs out of hospitals, provider offices, and infusions centers and instead have the drugs administered in patients' homes. In this home infusion model, a specialty pharmacy ships the prescription to the member and a visiting home health nurse administers the drug. When it is clinically appropriate, home infusion is often the lowest cost site of care. (Counce, 2019)

Cost savings for the bagging and home infusion options vary from payer to payer, based on contracts the payers have with their specialty pharmacies.

In April 2020 Anthem Blue Cross notified providers, they were required to obtain a select number of medical specialty pharmacy medications that were administered in a provider's office or outpatient hospital setting through CVS Specialty Pharmacy for commercial Health Maintenance Organizations (HMOs), beginning July 1, 2020.

On December 2, 2020, two notable changes occurred. First, Anthem Blue Cross expanded the program to commercial Preferred Provider Organizations (PPOs) and Exclusive Provider Organizations (EPOs). Second, UHC began requiring commercial plans in most states to source drugs through a specialty pharmacy UHC has agreements with.

In September 2020, Cigna put out a notice that certain specialty medical injectables must be dispensed and the claims must be submitted by a specialty pharmacy with which Cigna has a reimbursement arrangement. Cigna informed providers that it would not reimburse facilities that purchase injectables directly from specialty pharmacies that did not have a reimbursement arrangement with Cigna, manufacturers, or wholesalers. (Rumore & Dresser, 2021)

Quartz Health Insurance Corporation (Quartz) is one of the Board's health insurance providers. Quartz has a Specialty Pharmaceuticals Program for clients that get their pharmacy insurance through the company. Quartz does not provide pharmacy insurance to the Board's members, due to the Board's contract with Navitus. Quartz's Specialty Pharmaceuticals Program requires providers to obtain certain specialty drugs, referenced as level 4 drugs, through UW Health Specialty Pharmacy or Gundersen Health System Specialty Pharmacy. Once the provider has an approved

prior authorization for the medication, the patient can receive the medication by contacting the specialty pharmacy, requesting delivery by mail (white bagging) or by picking up at one of the pharmacy locations (brown bagging).

One strategy used by insurers and payers is to have a different copayment/coinsurance rate, depending on where a patient chooses to get their treatment. For example, if a person decides to receive their infusion/injection in a hospital outpatient department, some studies have found they pay more out of pocket than if the patient went to a provider's office. This pricing differential is in response to some hospital outpatient departments charging more for the same drug than when the drug is administered in a provider's office. (Robinson, Whaley, & Brown, 2021)

As the need for and price of specialty drugs increases, so too will the use of models such as bagging and in-home infusions/injections in Wisconsin as well as nationwide.

Bagging, home-infusion, and different copayment/coinsurance rate for different sites of care are being implemented in the private sector more and more frequently. However, public sector specialty drug programs have been slower to implement any of these changes to their programs. Staff has been unable to find any subject matter expert or published material to explain this difference.

Specialty Drugs Under the GHIP

Currently, under the GHIP, specialty drugs that are administered in a hospital, medical provider's office, infusion center, or by a medical professional in a member's home are covered by the Board's medical insurance plans. Specialty drugs that are administered through either of the Board's specialty pharmacies, which are Lumicera Health Service Specialty Pharmacy and the University of Wisconsin (UW) Health Specialty Pharmacies, are covered under the Board's pharmacy benefit.

Specialty drugs administered through the medical benefit are subject to the annual medical out-of-pocket limit (OOPL). The current OOPL is $1,250 for an individual and $2,500 for a family under the It's Your Choice (IYC) Health Plan or $2,500 for an individual and $5,000 for a family under the High Deductible Health Plan (HDHP).

According to data from the Data Analytics and Insights (DAISI) data warehouse, $226,110,667 was paid between 2018 to 2020 by medical insurers for specialty drugs administered at outpatient hospitals and end-stage renal disease facilities (facility outpatient) and provider offices, patient's homes, independent labs, and rural health clinics (professional facility).

Table 1. Medical Insurers Specialty Drug Spend 2018-2020

	2018		2019		2020	
Service Category	Patients	Total Spend	Patients	Total Spend	Patients	Total Spend

Outpatient Facility	2,014	$40,018,364	2,085	$45,045,072	2,072	$45,516,164
Professional Facility	4,440	$29,593,692	4,429	$31,284,912	4,340	$34,652,473

When an outpatient facility or professional facility administers a specialty drug, it charges not only for the price of the drug but also administration fee and facility charges. Administration fees can be for things such as provider and staff time, paperwork, and writing of prescription renewals. Facility charges are customarily for overhead items, often referred to as keeping the lights on. (Sorrel, 2013)

Through DAISI, staff was able to obtain information on administrative costs paid for members receiving specialty drugs from June 2020 through May 2021.

Table 2. Admin Costs for Specialty Drugs Through Medical Benefit

Service Category	Cost Type	Patient Visits	Allowed Amount Prof.	Allowed Amount Fac.	Allowed Amount Per Patient Visit	Percentage of Admin. Cost
Facility Outpatient Specialty Drugs	Admin Codes Only	9,395		$4,819,884	$513	**10.6%**
	All Costs	10,760		$45,286,782	$4,209	
Professional Specialty Drugs	Admin Codes Only	2,268	$1,024,363		$452	**3.0%**
	All Costs	10,457	$33,747,837		$3,227	

Under the current pharmacy benefit, specialty drugs are level 4 drugs. In 2020 and 2021 non-Medicare members had a $50 copay for all level 4 drugs and were required to fill that prescription at either Lumicera Health Service Specialty Pharmacy or UW Health Specialty Pharmacies. The prescription out-of-pocket limit (OOPL) for level 4 drugs is $1,200 for an individual or $2,400 for a family under the IYC Health Plan and $2,500 for an individual and $5,000 for a family under the HDHP.

In 2020 there were 27,650 Level 4 drug prescriptions filled under the pharmacy benefit. This was 1% of the total prescriptions filled in 2020. The total cost for all Level 4 drugs was $189,912,759 or 49% of the total pharmacy spend. That means 1% of all members filling prescriptions account for 49% of the costs.

Navitus is paid a Per Member Per Month fee to administer the pharmacy benefit program. That fee is the only administrative cost the Board pays to Navitus. The 2018-2020 Navitus administrative costs are provided in Table 3.

Navitus is under a contracted obligation with the Board to pass through all rebates and network discounts the company receives for drugs administered to members. By contrast, neither providers or health insurers are obligated to pass along any rebates or discounts they receive from drug manufacturers for the drugs administered or provide any information about agreements with manufacturers. From 2018-2020, Navitus passed through $834,617,029 in rebates and network discounts.

Table 3. Pharmacy Benefit Network Discounts, Rebates and Admin Fees 2018-2020

	2018	2019	2020
Network Discounts	$297,076,688	$316,526,426	$343,127,310
Rebates	$46,065,776	$50,872,053	$60,948,776
Admin Fee	$5,257,182	$4,194,969	$4,341,457

It should be noted that the Board's contract with Navitus is unique in many ways when compared to other PBM contracts. Not only does Navitus provide total pass through of rebates and discounts to the Board, Navitus provides full transparency. This allows entities such as the Legislative Audit Bureau (LAB) and the Board's third-party auditor, PillarRx Consulting, LLC to see every aspect of Navitus's business. This transparency makes comparing the Board's specialty drug program to health insurers and other PBM's difficult because those other programs lack the openness of the Board's program.

Analysis of Board Initiative

Navitus and ETF signed a Data Use Agreement in May 2021 to allow ETF, through the department's data warehouse vendor IBM Watson Health, to share medical insurance specialty pharmacy information from December 2019 through November 2020 from ETF's data warehouse with Navitus. Navitus offers the expertise of their pharmacists and industry experts to examine medical pharmacy data to all their clients at no charge.

Navitus compared drug costs under the medical benefit versus the cost under the pharmacy benefit. Navitus also examined the medical benefit data specific to sites of care where medications are provided (e.g., hospitals, clinics, infusion centers, etc.) to help identify if there were equally accessible, less expensive locations/options for members to receive medications.

On July 7, 2021, Navitus issued its Specialty Pharmacy Site of Care Analysis report. That report is confidential Attachment A to this memo.

Navitus's analysis found that about $66.4 million of specialty drug costs were paid under the medical benefit for the year of data that was examined. Navitus found that if these same drugs had been processed through the pharmacy benefit instead of the medical benefit the spending would have been about $49 million, a savings of $17.4 million.

ETF shared this analysis with and/or spoke to outside advisors to gain insight into the pharmacy and medical pharmacy landscape. Those consulted included the vice president of Pharmacy Benefits consultant at Segal Consulting, IBM Watson's pharmacy subject matter expert, the Wisconsin Office of the Commissioner of Insurance (OCI) regarding complaints it may have received from providers and patients about bagging of specialty drugs, and a private sector client of Navitus with a bagging and home infusion program administered by Navitus.

ETF learned from these outside advisors that there is no one-size-fits-all approach to moving drugs from the medical benefit to the pharmacy benefit, as each population is different and presents unique challenges. Any change will require communication to both members and providers.

As of early October 2021, OCI reported it had only received complaints from providers about the bagging of specialty drugs – none from patients.

IBM Watson's subject matter expert advised analyzing the average days between member doses and how a drug is dosed. ETF asked Navitus to supply this information. Staff will provide this and other information and recommendations at the May 2022 Board meeting.

ETF worked with Navitus to answer many of the questions brought up through literature review and speaking with outside advisors. One of the biggest arguments regarding any bagging option is that bagging results in an increase in wasted drugs.

In a letter to the Governor's Task Force on Reducing Prescription Drug Prices, the Wisconsin Hospital Association (WHA) wrote, *"White bagging and brown bagging may also result in waste of these expensive drugs. A drug obtained through white and brown bagging may only be administered to the patient for whom it was ordered. If there is any excess of the drug in the vial after the treatment, that excess must be discarded."* (State of Wisconsin Governor's Task Force On Reducing Prescription Drug Prices, October 2020)

When asked about the issue of waste in bagging Navitus states that there is a minimal amount of waste in all vials because of federal regulations set by the Food and Drug Administration (FDA) of vial and container sizes for many medications including specialty drug. For example, a specialty drug like Inflectra, which is administered intravenously to treat chronic inflammation, is given based on a patient's weight with patients receiving between 500 milligrams (mg) to 1,000 mg. Pfizer, the manufacture of the drug states on their website that the drug is shipped in 100 mg single-use vials. Under federal regulations no one can split a 100 mg single-use vial. If a patient, because of their weight, requires 675 mg of Inflectra there is going to be 25 mg left over regardless of bagging or not.

Opponents of bagging argue that a provider would then take that extra 25 mg and administer it to another patient. However, according to Navitus, providers would have to have another patient taking that same medication scheduled for the next appointment because the shelf life of an open vial is extremely limited. Navitus stated to ETF that additional waste from bagging would be minimal.

Sara Sadownik, deputy director of research and cost trends at the Massachusetts Health Policy Commission stated regarding white bagging*, "We heard from payers, even with drug waste, it's still a lower-cost practice."* (Abrams Kaplan, 2021)

The other concern we heard from people we spoke with was that any change in sourcing specialty drugs could lead to member confusion. Staff and Navitus agree that brown bagging would be the most confusing to members. After speaking to Navitus's nationwide client and reading about other payers' experiences, white bagging appears to offer the best option with the lowest chance of member confusion. A member would still go to the same location and have a specialty drug administered. The member would not have to handle the drug or see any change in the administration of the drug. The only change the member would see would be that they would receive two, rather than one Explanation of Benefits (EOB). A member would receive an EOB from the PBM for the drug and the medical insurance for the administration of the drug.

Navitus has committed to partnering with ETF for member education through mailings, webinars, extra customer service coverage or any other way necessary in any change the Board would decide to make. The nationwide client of Navitus' who ETF spoke with thought highly of Navitus' ability to educate members and providers in ways of the client's pharmacy benefit program.

Opposition to Implementing Specialty Pharmacy Changes
On October 21, 2021, the legislature began circulating LRB 4440/1 for co-sponsorship. According to the Legislative Reference Bureau's analysis of the proposed legislation, an insurer offering a health benefit plan, a pharmacy benefit manager, or an agent of the insurer or pharmacy benefit, would be prohibited from:

- Refusing to authorize, approve, or pay a participating provider for providing a covered clinician-administered drug and related services to an enrollee, policyholder, or insured.
- Condition, deny, restrict, refuse to authorize, or approve, or reduce payment to a participating provider for a covered clinician-administered drug and related services when all criteria for medical necessity are met because the provider obtains the drug from an entity that is not selected by the plan.
- Prohibit health benefit plan designs that prevent participating providers from receiving reimbursement for a covered clinician-administered drug and any related services at an applicable rate as specified in the contract.
- Impose coverage or benefit limits, or require an enrollee, policyholder, or insured to pay an additional fee, higher copay, or coinsurance, second copay or

coinsurance, or penalty when obtaining a clinician administered drug from an authorized health care provider or pharmacy.

- Require an enrollee, policyholder, or insured to pay an additional fee, higher copay, or coinsurance, second copay or coinsurance, or other form of a price increase for a clinician-administered drug when the drug is not dispensed by a pharmacy or acquired from an entity that is selected by the plan
- Interfere with an enrollee's, policyholder's, or insured's right to choose to obtain a clinician-administered drug from a participating provider or pharmacy of choice.
- Limit or exclude coverage for a clinician-administered drug when not dispensed by a pharmacy or acquired from an entity selected by the plan when the drug would otherwise be covered.
- Require a pharmacy to dispense a clinician-administered drug directly to an enrollee, policyholder, insured, or the insured's agent with the intention that the individual will transport the drug to a health care provider for administration.
- Require or encourage the dispensing of a clinician-administered drug to an enrollee, policyholder, or insured in a manner that is inconsistent with the federal Drug Supply Chain Security Act.
- Require that a clinician-administered drug be dispensed or administered to an enrollee, policyholder, or insured in the residence of the enrollee, policyholder, or insured or required the use of an infusion site external to the office or clinic of the enrollee's, policyholder's, or insured's provider.

The drafted legislation is supported by WHA and the Pharmacy Society of Wisconsin. This legislation mirrors language from similar pieces of legislation that have been proposed across the country and signed into law in Louisiana.

LRB 44401/ is called Koreen's Law after Koreen Holmes, a woman from Eau Claire who was five months into treatment for breast cancer, receiving an infusion every three weeks when her health insurance company implemented a white bagging policy for her infusion medication. Because the hospital where Ms. Holmes was receiving treatment has a policy of not using medications from outside sources. Ms. Holmes would have either had to change locations for her infusions or pay for the medication out of pocket. Ms. Holmes was able to get a 90-day continuance from her insurance company that allowed infusions to be covered through the end of infusion treatments. (Lindquist, 2021)

The current draft of LRB 4401/1 if signed into law would restrict the Board's ability to change how specialty drugs are administered using any of the courses of action explained in this memo. As of the writing of this memo the bill draft has not been formerly introduced or scheduled for a public hearing.

Future Considerations

There are a variety of approaches the board could take when it comes to addressing the changing landscape of specialty drugs. Below are some of the approaches the Board could consider. This is not intended to be a complete list. It serves a starting point for

Board discussion and provides an example of the types of issues that need to be considered in making this decision. A complete list and potential recommendations will be provided at the May meeting. This will allow ETF to complete additional research and provide a more comprehensive assessment to the board. This research will include talking to outside stakeholders such as, but not limited to, members, vendors, and providers. to-date. It should be noted that none of these approaches are mutually exclusive, therefore more than one approach can be offered to members.

<u>Implement brown bagging for all drugs mentioned in Navitus's report (minus those mentioned for contraception)</u>
With this approach a member would either go to a pharmacy or have the specialty drug shipped to their home. The member would then have to bring the drug to the provider's office, hospital, infusion center for the medical professional to administer the treatment.

- Pros
  - The Board would pay a lower cost for the drugs administered through the pharmacy benefit.
  - The Board could realize even more savings with Navitus's full pass through of rebates and discounts.
- Cons
  - An increase in the number of people handling a drug before administration.
  - Members would be responsible for making sure the drug was kept in the right environment.
  - Of all the options could lead to the most member confusion and drug waste.

<u>Implement white bagging program for all drugs mentioned in Navitus's report (minus those mentioned for contraception)</u>
With this approach a provider would have to contact Navitus's specialty pharmacy, Lumicera, and order the specialty drug. The drug would then be delivered to the provider for administration at the member's appointment.

- Pros
  - The Board would realize more savings than it is currently receiving.
  - The drug is sent directly to the provider from the specialty pharmacy without handling from the member.
- Cons
  - Oncology drug dosages are based on a patient's weight on the day of treatment and weight can fluctuate when being treated for cancer. This could lead to waste if the member's weight has dropped or not enough of the drug on hand if the member has gained weight.
  - Receiving drugs through the pharmacy benefit but having them administered through the medical benefit will lead to members receiving more billing and paperwork, which could lead to member confusion.

<u>Implementing a white bagging program for all drugs except oncology and contraception and a clear bagging program in the University of Wisconsin (UW) hospital system</u>

With this approach the Board could ease into offering a white bagging program by not moving all specialty drugs to the pharmacy benefit. Those in the oncology field have voiced concern about moving drugs used to treat cancer to a white or brown bagging option due to the complexity of anticancer drugs which often require dose adjustments and treatment delays. (Ferguson, 2021)

This approach would also allow for easing into offering clear bagging. Clear bagging allows a provider's internal specialty pharmacy to dispense the member's level 4 drug and transport the drug to the medical professional who will be administering the drug. UW Specialty Pharmacy is already one of the two specialty pharmacies commercial members must use to get their level 4 drugs through the pharmacy benefit.

- Pros
  - This option allows for the easing into a big change to how the members receive their specialty drugs. This approach would allow for growth and expansion of clear bagging into other health systems with specialty pharmacies.
  - This choice would not disrupt or change how members receiving oncology drugs receive their drugs during treatment.
- Cons
  - ETF and Navitus have not spoken to UW Specialty Pharmacy about this option so there is uncertainty if they would be willing to enter into an agreement.
  - There is a chance of drug waste with white bagging. Depending on how drugs are packaged, a member may not need a whole vial of a specialty drug, so what is left over will need to be disposed of. Navitus reported that even with the potential for drug waste, the Board could save over $17 million.

<u>Create a 20% coinsurance rate for all infusions received in a hospital outpatient setting.</u>
With this approach a member who receives their injection/infusion in a hospital outpatient clinic would pay 20% coinsurance, in addition to any other deductibles or coinsurances.

- Pros
  - This new coinsurance could be used to help offset the possible significantly higher costs paid for infusions received in hospital outpatient clinics when compared to other sites of care.
  - This additional coinsurance could help drive members to other infusion/injection settings that would lead to a lower cost for members and the GHIP.
- Cons
  - This approach is a price increase for members who would continue to receive their infusions in hospital outpatient clinics.
  - This change in payment could lead to member confusion due to the site of care possibly being unclear to members. Members believe they are going to a clinic for their treatment; however, they are getting infusions at a hospital outpatient clinic.

- With this option, payments for the infusion would remain under the medical benefit therefore the Board would not receive any rebates for the drug.

Allow for home infusion for all non-oncology drugs

With this approach a member's medical provider will contact Lumicera with their prescription for a level 4 drug. Lumicera would then fill that prescription and ship the drug to the member's home. A registered nurse with home health care provided under the contract with Navitus would administer the drug to the member in the member's home.

- Pros
  - This approach allows the member to receive their injection/infusion in their own home, helping to alleviate any transportation issues a member may have.
  - This approach also reduces the amount of human interaction a member would need to have at a time in their life where they may be very vulnerable to germs and diseases others may carry.
  - Navitus works with Option Care, Coram, and Accredo in Wisconsin to administer drugs at home and can utilize Optum, which has an infusion operation.
- Cons
  - With this approach, a member would have to handle and care for the drug before the home health provider arrives to administer the drug.
  - The number of tests that home health providers can administer before giving the member the drug is limited compared to the tests that could be run in a medical setting like a provider's office, hospital, or infusion center.
  - Staff has concerns about the availability of home health in rural areas.

No change

With this approach the Board decides to make no change and continues to cover specialty drugs administered by medical providers only through the medical benefit.

- Pros
  - No possible member disruption or possible provider displeasure.
  - Hospitals, medical providers, and infusion centers continue to receive the same amount of revenue from the Board's members.
- Cons
  - The Board does not realize any of the savings identified by Navitus.
  - Member premiums will likely increase to help cover the cost of specialty drugs administered through the medical benefit.

Next Steps

ETF will consult with stakeholders such as members, providers, and the Board's contracted health plans in order to gather feedback from as many stakeholders as possible.

At the May 2022 Board meeting, ETF will request Board action regarding what approach to take on medical and pharmacy benefits related to specialty drugs. Any approved changes would take effect January 1, 2023.

Staff will be available at the Board meeting to answer any questions.

Attachment A: Specialty Pharmacy Site of Care Analysis (confidential)

Bibliography

Abrams Kaplan, D. (2021, February 21). How 'White Bagging' Affects Patients, Physicians and 340B Funding. *Managed Healthcare Executive*.

American Journal of Managed Care. (2013, February 18). *American Journal of Managed Care*. Retrieved from American Journal of Managed Care: https://www.ajmc.com/view/the-growing-cost-of-specialty-pharmacyis-it-sustainable

Chand, S., Ramesh, B., Sah Sujit, K., & Kala Bahadur, R. (2019). Brown, White and Blue Bagging in Special Pharmacy: An Emerging Trend to Minimize Medication Error. *Journal of Global Pharma Technology*, 1-4.

Counce, J. (2019, May/June). Home Infusion's Expanding Role in Optimizing Site of Care. *Infusion Magazine*, pp. 37-44.

Ferguson, K. (2021). Recent Trends in White Bagging and Brown Bagging. *Oncology Issues*, 8-9.

Hoffman, S., & Buck, I. D. (2020). Specialty Drugs and the Health Care Cost Crisis. *Wake Forest Law Review*, 59-60.

Keck Medicine of USC. (2021, February 18). *California State Board of Pharmacy.* Retrieved from White Bagging Informational Hearing: https://pharmacy.ca.gov/meetings/agendas/2021/keck_presentation.pdf

Lindquist, E. (2021, October 26). Bill to end health insurance practice known as 'white bagging' named after Eau Claire cancer patient. *Eau Claire Leader-Telegram*.

Robinson, J. C., Whaley, C. M., & Brown, T. T. (2021). Price Differences To insurers For Infused Cancer Drugs in Hospital Outpatient Departments and Physician Offices. *Health Affairs*, 1395-1401.

Rumore, M. M., & Dresser, J. C. (2021, January 6). *Frier Levitt Attorneys at Law*. Retrieved from Emerging Trends in Payor-Mandated White Bagging: https://www.frierlevitt.com/articles/emerging-trends-in-payor-mandated-white-bagging/

Sorrel, A. L. (2013, April 17). Extra Fee, Extra Hassle: Charging Patients Extra Fees May Hurt, Not Help. *Texas Medicine*, pp. 27-31.

State of Wisconsin Governor's Task Force On Reducing Prescription Drug Prices. (October 2020). *Report of the Governor's Task Force on Reducing Prescription Drug Prices.* Wisconsin: State of Wisconsin.

Tichy, M. E., Hoffman, J. M., Suda, J. K., Rim, M. H., Tadrous, M., Cuellar, S., . . . Shumock, G. T. (2021, April 21). *National trends in prescription drug expenditures and projections for 2021*. Retrieved from US National Library of Medicine National Institutes of Health: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8365501/#sup2

U.S. Food & Drug Administration. (2021, October 8). *Novel Drug Approvals*. Retrieved from U.S. Food & Drug Administration: https://www.fda.gov/drugs/new-drugs-fda-cders-new-molecular-entities-and-new-therapeutic-biological-products/novel-drug-approvals-2021

United States Department of Health and Human Services. (2020, May 22). *Updated Contract Year (CY) 2021 Final Part D Bidding Instructions*. Retrieved from U.S. Department of Health and Human Services: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/2021%20mtm%20and%20specialty%20thresholds%20final%20part%20d%20bidding%2005.22.2020_8.pdf

Wisconsin Department of Employee Trust Funds. (2021, April 1). *State of Wisconsin Pharmacy Benefit Programs Fact Sheet 2020.* Retrieved from Wisconsin Department of Employee Trust Funds: https://etf.wi.gov/publications/et8933/direct