



January 29, 2024

House Health and Human Services Committee
Colorado General Assembly
200 E Colfax Avenue
Denver, CO 80203

RE: Amend HB24-1010 Insurance Coverage for Provider-Administered Drugs

Chair Daugherty, Vice Chair Young and Members of the Committee,

The American Society of Health-System Pharmacists (ASHP) strongly supports efforts to protect patients by prohibiting insurers and pharmacy benefit managers (PBMs) from limiting access to provider-administered drugs by requiring such drugs to be dispensed exclusively from a narrow network of payer-affiliated mail order pharmacies in a practice commonly known as “white bagging.”

Payer-mandated white bagging increases patients’ out-of-pocket costs, causes unnecessary treatment delays and degrades the overall patient experience across all settings of care. Therefore, **we urge the committee to amend HB 24-1010 to apply to all providers as defined in Section 10-16-102 (56) without exception.**

ASHP is the largest association of pharmacy professionals in the United States, representing 60,000 pharmacists, student pharmacists, and pharmacy technicians in all patient care settings, including hospitals, ambulatory clinics, and health-system community pharmacies.

What is ‘white bagging’ and ‘brown bagging’?

White and brown bagging refer to an insurer-driven practice wherein coverage for provider-administered drugs (such as IV infusions) is conditioned on the drug being dispensed from a payer-affiliated mail order pharmacy. White bagging occurs when the drug is shipped from a mail order pharmacy directly to the hospital or clinic that administers the drug. Brown bagging occurs when the drug is shipped directly to the patient, who is then responsible for storing, handling and transporting the drug to a medical facility for administration.

Mandatory white and brown bagging policies degrade overall quality of care.

A recent study by Moffitt Cancer Center determined that payer-mandated white bagging is associated with a 11.4 percent increase in delayed treatment amongst chemotherapy patients. The study also found that only 48 percent of white bagged drugs arrived in the appropriate time window for administration and 6.5 percent of all white bagged drugs were not even shipped from the plan-affiliated pharmacy until after the patient’s dose was already overdue. The study also estimated that an additional 25 percent of the on-time treatments were “near misses” wherein the hospital’s clinical care coordinators had to intervene on the patient’s behalf to prevent a delay.¹

¹ Komorny et. al, Payer site of care mandates with oncology medications: It’s time to demand payer accountability on behalf of patients, *American Journal of Health-System Pharmacy*, 2023;,, zxad078, <https://doi.org/10.1093/ajhp/zxad078>

Additionally, there is strong clinical consensus that requiring a patient to store, handle and transport their own medications (brown bagging) prior to administration places undue burdens on the patient and greatly increases the risk of medication-related errors, adulteration and other complications.

In light of the associated safety and operational risks, **ASHP strongly believes that white bagging should be reserved to very limited circumstances when necessary to ensure patient access to rare and unusual therapies that are not typically available from the patient’s healthcare provider and that brown bagging should be avoided whenever possible.**

White bagging increases patients’ out-of-pocket costs.

Payers insist that white bagging and brown bagging saves money and reduces costs – but for whom? A 2023 analysis of commercial insurance claims found that bagging increased oncology patients’ out-of-pocket costs by \$180 per month on average.² Further, none of the 212 patients included in the Moffitt study indicated they felt that white bagging policies were saving them money, but several patients indicated that their out of pocket expenses actually increased when their plans implemented mandatory white bagging policies.¹

Legislation is necessary to protect Colorado patients and ensure the highest quality of care.

The three largest PBMs – UnitedHealth Group’s OptumRX, CVS Health Corp’s CVS Caremark and Cigna’s Express Scripts – process nearly 80 percent of all prescription claims in the United States. All three insurers also own and operate networks of mail order specialty pharmacies. Policies like mandatory white bagging ensure that the maximum amount of professional service fees and reimbursement associated with delivery of covered care are captured exclusively by commonly-owned entities. This is the only rational explanation as to why payers insist on requiring a means of distribution that is needlessly complicated and in violation of the basic core principles of supply chain management and process efficiency.

Policymakers should ensure that plans and PBMs are required to permit participating providers and pharmacies, across all settings of care, to acquire and dispense covered provider-administered drugs to patients on equitable terms. This would promote competition by permitting qualified non-affiliate entities equal opportunity to provide the highest quality of covered services to patients.

Thank you for the opportunity to testify in support of this bill. If you have any additional questions or would like further information please contact Kyle Robb (krobb@ashp.org)

Respectfully,



Kyle Robb, PharmD
Director, State Policy & Advocacy
ASHP

² Shih YT, Xu Y, Yao JC. Financial Outcomes of “Bagging” Oncology Drugs Among Privately Insured Patients With Cancer. JAMA Netw Open. 2023;6(9):e2332643. [doi:10.1001/jamanetworkopen.2023.32643](https://doi.org/10.1001/jamanetworkopen.2023.32643)

Gary R. Feldman, MD, FACR
President

January 30, 2024

Madelaine A. Feldman, MD, FACR
VP, Advocacy & Government Affairs

House Health Care & Health Insurance Committee
200 E Colfax Ave.
Denver, CO 80203

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Gregory W. Niemer, MD
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Joshua Stalow, MD
Director

Re: Support for HB 1010

The Coalition of State Rheumatology Organizations (CSRO) is a national organization composed of over 30 state and regional professional rheumatology societies. CSRO was formed by physicians to ensure excellence and access to the highest quality care for patients with rheumatologic, autoimmune, and musculoskeletal disease. It is with this in mind that we write to you regarding HB 1010.

As you consider HB 1010, CSRO would like to share its support, and the importance of ensuring that providers continue to be able to provide care for patients through the buy and bill acquisition model for provider administered prescription drugs.

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

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

White Bagging Reduces Patient Safety and Increases Practice Liability

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

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Executive Director

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

White Bagging Requirements Delay Care and Increase Drug Waste

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

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

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

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

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

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

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Ann Marie Moss
Executive Director

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

White Bagging Requirements Reduce Affordability for Patients

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

For these reasons, CSRO requests your support for HB 1010. We appreciate your consideration of our comments.

Respectfully,



Gary Feldman, MD, FACR
President
Board of Directors



Madelaine A. Feldman, MD, FACR
VP, Advocacy & Government Affairs
Board of Directors



The Nation's Advocacy Voice for In-Office
Infusion

3307 Northland Dr, Ste 160 ▪ Austin, TX 78731
www.infusioncenter.org ▪ info@infusioncenter.org

Chairperson Lindsey Daugherty
CO Health & Human Services Committee
200 E Colfax Avenue

January 30, 2024

Re: Support for Colorado HB24-1010

Dear Chairperson Lindsey Daugherty and Honorable Members of the CO Health & Human Services Committee:

On behalf of the infusion providers we represent in your state, thank you for your service and commitment to the people of Colorado. As a nonprofit trade association that provides a national voice for non-hospital, community-based infusion providers; we ask that you please support HB24-1010.

The National Infusion Center Association (NICA) is a nonprofit organization formed to support non-hospital, community-based infusion centers caring for patients in need of infused and injectable medications. To improve access to medical benefit drugs that treat complex, rare, and chronic diseases, we work to ensure that patients can access these drugs in high-quality, non-hospital care settings. NICA supports policies that improve drug affordability for beneficiaries, increase price transparency, reduce disparities in quality of care and safety across care settings, and enable care delivery in the highest-quality, lowest-cost setting.

In the infusion space, reimbursement rates for drug administration do not cover the actual expense of administering medications. Infusion providers have historically relied on what is known as "buy-and-bill" to purchase medications for their practices in bulk and then billing patients for their individual treatments. Margins incurred from the buy-and-bill model allow offices to cover administration and overhead costs, and ultimately keeps community-based providers in business.

However, some insurance companies have implemented policies that require Colorado patients to purchase medications from specialty pharmacies—a practice known as "white bagging."



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When a payor requires a patient's medication to be acquired from a specialty pharmacy, the drug is provided by a third-party pharmacy, generally one the payor is affiliated with, and the provider bills for administration only. Specialty pharmacy mandates circumvent the buy-and-bill model infusion providers rely on. If Colorado infusion centers can no longer afford to treat patients due to forced "white bagging," their long-standing patients who rely on them for consistent, local, and quality care will have nowhere to go.

In addition to disrupting the economics of non-hospital infusion offices, specialty pharmacy mandates add unnecessary waste and costs, and ultimately harm patients. White bagging requires that patients pay for their medications before they receive them and before they are even shipped to their providers' offices. If for any reason a patient is unable to receive their treatment, due to weight fluctuation or a change in their condition, that medication, which has already been paid for, is now wasted. However, the patient is still responsible for paying for the drug. By law, the drug cannot be returned, and it cannot be administered to another patient.

These medications cost thousands of dollars and wasting them is completely avoidable through the buy-and-bill model that infusion offices currently use. For many of our providers, working with a specialty pharmacy has led to delays and disruptions in treatment schedules. Practices have reported receiving different quantities than what was ordered or experienced processing and shipping delays.

On behalf of the providers we serve, we urge the CO Health & Human Services Committee to advance HB24-1010 and ensure healthcare providers have the flexibility to obtain and administer complex provider-administered drugs in the way that is right for their office.

Sincerely,

Kindyl Boyer

Kindyl Boyer

Director, Advocacy

National Infusion Center Association (NICA)

Madam chair and members of the committee, thank you for the opportunity to submit this written testimony in support of HB24-1010.

My name is Marilyn Siayap, I am the Director of Pharmacy Services at WellPower, the community mental health center of Denver, where I oversee the management of two pharmacies and a wide array of clinic services. I was regrettably unable to testify in person today, but I am pleased to submit this written testimony on behalf of WellPower in support of HB24-1010.

As you know, this bill addresses an arrangement made by a health insurance carrier to distribute a medication from a designated pharmacy directly to the physician's office, hospital, or clinic for administration to a specific patient. This arrangement is commonly referred to as 'white bagging'. The medications are often injectables or infusible medications that must be administered by a health care provider.

WellPower supports this bill because white bagging takes away patient's choice of pharmacy, undermines patient safety, and hinders providers' ability to adjust medication dosage at the time of administration.

White bagging hinders the ability of our pharmacists to ensure the integrity of medication and supply chains. When we acquire medications, we are required by the FDA to conduct track and trace on each medication to verify how the drugs have been handled since they were manufactured. With white bagging, we can no longer assure the product has not experienced tampering or that it was stored correctly before it is delivered to the clinic.

The negative effects of white bagging on patient choice and wellbeing are also significant. Allow me to describe a person we serve who entered treatment for Substance Use Disorder this past January. The person has been in services with WellPower and used our pharmacy for the past 7 years. In January, they agreed to start treatment with an injectable medication found to be successful in the treatment of persons with a Substance Use Disorder. After several phone calls by both pharmacy staff and clinic nursing staff, it was discovered the insurance required the medication to be filled by a specific pharmacy and delivered to the clinic. The person was not comfortable using an unknown pharmacy and she withdrew from treatment of her Substance Use Disorder. This individual really needed our care, and we could not give her what she needed due to insurance restrictions.

Another person we serve has a prescription for a long-acting injectable schizophrenia medication. The medication is required to be delivered to the clinic from a specialty pharmacy, but often does not arrive in time for the individual's scheduled appointment, forcing the person to make multiple bus trips back to the clinic.

The integrity of medication and the safety of patients is paramount in our work, and the practice of white bagging undermines these goals. I urge you to vote yes on this bill.

Thank you for your time.



February 27, 2024

Representative Lindsey Daugherty, Chair
House Committee on Health and Human Services
Colorado General Assembly
200 E Colfax Avenue
Denver, CO 80203

Dear Chair Daugherty and Members of the House Committee on Health and Human Services,

The Rocky Mountain Oncology Society (RMOS) and the Association for Clinical Oncology (ASCO) are pleased to support **HB 1010**, which would prohibit mandatory white bagging requirements from insurers so that patients can obtain clinician-administered drugs from their health care providers, thereby preserving timely and consistent delivery of high quality, patient-centered care. We appreciate the Committee's efforts to address payer-mandated white bagging and urge the Committee to amend HB 1010 to apply to all settings of care.

Formed in 1991, RMOS is a diverse community of oncology professionals whose mission is to promote the highest professional standards of oncology, research and exchange information and ideas leading to improvements in oncology. ASCO is the world's leading professional society representing physicians who care for people with cancer. With nearly 50,000 members, our core mission is to ensure that patients with cancer have meaningful access to high-quality, equitable cancer care.

Traditionally, the acquisition of anti-cancer drugs is managed in the independent practice or hospital setting where chemotherapy administration is overseen by the treating physician. The practice or hospital pharmacy purchases, stores, and administers these agents under strict handling and administration standards.

Although clinicians prepare detailed treatment plans, drug regimens often change on the day of treatment due to clinical circumstances. Administration may be adjusted according to criteria such as patient weight, comorbidities, lab reports, guidelines, and other clinical data. Under a mandatory white bagging policy, insurers require physicians to obtain drugs purchased and handled by payer-owned or affiliated pharmacies, which requires additional coordination with patients and physicians and could delay or disrupt treatment plans and decisions. Day-of treatment changes can lead to a delay in care if a physician must place a new order, requiring the patient to return on a later date to receive their treatment. This can result in significantly decreased chances of a successful clinical outcome for the patient.

When treatment plans are modified on the day of treatment, mandatory white bagging policies can also lead to waste if an unused portion of a previously dispensed drug cannot be used for a different patient. Many anti-cancer drugs are highly toxic and require special handling when discarded. The burden of unnecessary waste related to white bagging falls to practices and hospitals, which must dispose of drugs according to state and federal requirements.

Payer-mandated white bagging is often managed as a pharmacy benefit, whereas the traditional administration of anti-cancer drugs is managed as a medical benefit. Patients' out-of-pocket costs under the pharmacy benefit are often different and may be higher than they would be if the clinician-administered drug was covered under the medical benefit. Additionally, patients receive little or no support from payer-owned or affiliated specialty pharmacies in way of co-pay assistance or foundation support.

RMOS and ASCO recognize that white bagging may be necessary in some settings and acknowledge the bill does not ban the practice. However, mandatory white bagging is not appropriate and can jeopardize the delivery of high-value, high-quality care. For these reasons, we support any efforts to prohibit mandatory white bagging in Colorado. For a more detailed understanding of our policy on this issue, we invite you to read the [ASCO Position Statement on White Bagging](#) by our affiliate, the American Society of Clinical Oncology. RMOS and ASCO welcome the opportunity to be a resource for you. Please contact Nick Telesco at ASCO at Nicholas.Telesco@asco.org if you have any questions or if we can be of assistance.

Sincerely,

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Tejas Patil, MD
President
Rocky Mountain Oncology Society

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Everett E. Vokes, MD, FASCO
Chair of the Board
Association for Clinical Oncology



February 2, 2024

Representative Lindsey Daugherty, Chair
House Committee on Health and Human Services
Colorado General Assembly
200 E Colfax Avenue
Denver, CO 80203

Dear Chair Daugherty and Members of the House Committee on Health and Human Services,

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Tejas Patil, MD
President
Rocky Mountain Oncology Society

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Everett E. Vokes, MD, FASCO
Chair of the Board
Association for Clinical Oncology