Cleveland Clinic

House Bill 451 – Proponent Testimony
House Insurance Committee
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Chairman Brinkman, Vice Chair Lampton, Ranking Member Miranda and members of the Ohio House Insurance Committee, thank you for the opportunity to testify in support of House Bill 451, which amends the law related to physician-administered drugs to address the practice known as “white bagging.” My name is Alexa Pugacz, and I am the Regional Oncology Clinical Pharmacist at Cleveland Clinic Avon Family Health Center

Cleveland Clinic hospital pharmacies support our inpatients with staff pharmacists, clinical pharmacy specialists and pharmacy technicians. In these settings, we frequently care for patients who are receiving infusion drug treatments for a variety of conditions, including cancer, rheumatological conditions, and multiple sclerosis. Treatment for these patients is highly personalized and must be tailored uniquely for each individual.

Unfortunately, recent utilization management policies implemented by some national insurance companies, known as “white bagging,” threaten to interfere with the ability to provide timely and effective care to patients, while also increasing patient costs. For those unfamiliar of the term “white bagging” , it is defined as the practice that allows insurers, rather than the patient’s pharmacist and healthcare provider, to determine when, where, and how drugs are purchased, prepared, and administered to patients.

This committee has previously heard from Cleveland Clinic’s Chief Pharmacist through written proponent testimony. In that testimony, we shared our strong support for the passage of House Bill 451, due to unnecessary and avoidable logistic, financial, administrative, and emotional burdens that white bagging places on both hospitals and patients.

I am here to expand upon what has already been shared by Cleveland Clinic, and focus on the many ways that white bagging negatively affects patients, including disrupting care, delaying treatments, creating stress, increasing cost, and creating safety concerns. I have witnessed firsthand the hardships and drawbacks that patients have experienced as a result of white bagging. Allow me to provide examples from Cleveland Clinic patients and their families who have shared their stories with me.

My first patient I would like to share will be referred to as “Patient M.”

Patient M is suffering from rheumatoid arthritis (RA), which is an autoimmune disease where one’s immune system attacks your joints, causing swelling, pain, and stiffness. If left untreated, it can result in permanent joint damage. Patient M is currently mandated by her insurance company to fill her intravenous medication through an external pharmacy. After several months of delayed treatment, we were finally authorized as a

clinical site for Patient M to begin infusions for management of RA. Over the span of six business days, I exhausted over 10 hours of clinic time to facilitate setting Patient M up with the “white-bagging” process for her insurance company. This process involves providing the external pharmacy with patient information, diagnosis, failed therapies, appropriate lab work, and ultimately the prescription. Once this is received, the external pharmacy begins its authorization process, which can span an additional 7-10 business days. From start to finish, without regard to the previous months of delayed therapy, the turnaround time for getting Patient M necessary therapy was approximately 21 days. Patient M has referred to the process of timely delivery of her medication as a “rabbit hole.” Not only is the process convoluted, but it also provides unnecessary stressors. Patient M’s most recent infusion was scheduled this past month. I called her external pharmacy and was notified that the patient will need to set up medication delivery herself. Patient M called as directed and was notified that the prescription she was inquiring about was no longer on file. Upon reaching out to her insurance company, Patient M was notified they switched contracts with external pharmacies, ultimately, starting this tortuous process all over again. Given that she receives her infusions every 8 weeks, this is unnecessary, untimely, and a detrimental stressor to the patient.

My next patient I would like to provide testimony for is “Patient X.”

Patient X has a longstanding relationship with Cleveland Clinic as a “white bag” patient that extends back to September of 2020 when she was admitted for acute, severe, steroid refractory colitis. Colitis is the inflammation of the lining of our large intestine, which causes debilitating pain, cramping, and abdominal distress. During her inpatient stay, she was started on immunotherapy infusions for treatment management. This particular medication can have numerous adjustments in doses as well as frequencies. Patient X was initially started on an every 8-week schedule and was set up through an external pharmacy to supply medication for each infusion. Upon analyses of Patient X’s response, the physician chose to increase frequency of infusion from every 8 weeks to every 4 weeks, thus requiring a new authorization through her external pharmacy. This change in the prescription resulted in a 14-day delay in treatment for Patient X. Another occurrence took place the past fall, when her insurance changed preferred formulary agents. This required the physician to write a new prescription with a biosimilar agent. Again, this resulted in a 2-week delay in Patient X’s infusions. Our latest incident occurred last Thursday. We were notified that upon Patient X’s most recent office visit with her provider that a dose increase was warranted based on Patient X’s breakthrough symptoms. Unfortunately, drug was already shipped out from the external pharmacy, resulting in Patient X potentially receiving an infusion at a lower dose than recommended. Thus, another example of untimely and unnecessary stressors resulting in delay of therapy in a severe diagnosis.

The stories of Patient M and Patient X are unfortunately all too common within the walls of our health system, and can be avoided through the passage of House Bill 451. Without white bagging, we would be able to provide higher level continuity of care and focus on clinical practices. White bagging risks patient safety, can lead to delayed care, and often drives up patient costs. Without these restraints, patients can be seen in a more timely

manner and avoid delays that can be detrimental to their health. These policies should be opposed by anyone who aims to fight for the interests of patients.

Cleveland Clinic is committed to being a partner to you in combating the issue of white bagging. We support House Bill 451 and urge the committee to be supportive as well. We thank the bill sponsors, Representative Scott Oelslager, and Representative Gayle Manning for championing this legislation. Thank you for the opportunity to provide testimony, and I am available to answer any questions you may have.