February 4, 2020

The Honorable Andrea Salinas, Chairman
House Committee on Health Care
Oregon House
900 Court St NE, HR-E
Salem, OR 97301

Re: House Bill 4102 - Opposed

Dear Representative Salinas,

Moda Health presents this letter in opposition to House Bill 4102, a bill that will make it difficult for carriers to run effective prescription drug management programs and will lead to higher health care costs. HB 4102 seeks to minimize the ability for carriers to administer utilization management tools that are employed to ensure that members receive the right care at the right time at the right cost. As drafted, it minimizes the important role that pharmacists play in prescription utilization management and may lead to higher health care costs for our clients.

Moda Health is a Northwest-based health insurer providing dental, medical and pharmacy insurance and administrative services in Oregon, Washington and Alaska. We take pride in the diversified range of clinical and pharmacy cost management services and strategies Moda Health deploys on behalf of the more than 1.3 million individuals in the Pacific Northwest for whom we provide prescription drug coverage. Moda Health is the administrator for Oregon's Prescription Drug Program, which includes over 200,000 members enrolled in the Oregon Educators Benefits Board, Public Employee Benefits Board, SAIF, Eastern Oregon Coordinated Care Organization, and other self-insured and government programs statewide, as well as over 300,000 underinsured and uninsured residents who benefit from the preferential drug prices that the OPDP discount card has made possible.

Moda's concerns with HB 4102 fall into four main areas listed below:

- **Section 5(2)(f). Removes the role of clinical pharmacists in managing decisions concerning the use of pharmaceuticals.**

  HB 4102 requires that insurers and entities "use a physician to make all final recommendations regarding coverage of treatment, drug or device that is subject to utilization review". It removes pharmacists, who are trained and licensed in pharmacology, from making decisions about the treatment, coverage and use of medications that are subject to utilization reviews. As worded, HB 4102 would extend to physicians all responsibilities concerning coverage decisions in the development and management of drug utilization reviews, instead of involving their expertise in making final coverage determination on claims that are appealed. By assigning this responsibility to physicians, many of whom may have one year or less of academic training in pharmacology and are not required by their board certification to remain current on the uses, HB 4102

undermines the value that pharmacists have in bringing clinical expertise to the selection and use of medications in utilization review criteria.

- **Section 5(2)(k). Requires insurers to provide coverage of treatments selected by a provider until all internal and external reviews are completed.**

  HB 4102 increases the burden on insurers to continue coverage for medications that have not satisfied utilization management protocols. Utilization management is a clinical tool used by clinicians who have researched the body of evidence to make determinations about drug selection and use. While appeal and grievance processes are established to allow additional evidence to be brought forward for consideration, mandating this requirement establishes a precedent for paying for any drug that has not been authorized for use through an entire appeal process. It may ultimately lead to further member dissatisfaction if treatment is covered by a plan for weeks or months during the appeal process and is subsequently not paid for if the appeals process doesn't result in a favorable coverage determination.

- **Section 3(1)(b). Requires that insurer IRO committees include at least one reviewer that is a clinician in the same or a similar specialty as the provider who prescribed the treatment that is under review.**

  Independent Review Organizations are, by definition, "independent." These are external organizations hired to review member or provider appeals and are unaffiliated with the insurer or carrier, and draw on the expertise of thousands of board-certified clinicians throughout the country. Since these are independent organizations, insurers and carriers have no ability to influence the composition of their IROs. Insurers and carriers have no ability to implement this requirement of HB 4102.

  During the appeal process, carriers may use third party review services to conduct reviews and can request a specialty match reviewer from that third party; however, the third party review service determines who the review is assigned to. Most third party review services charge hundreds of dollars per review, so requiring this type of review prior to the IRO stage of the appeals process will raise administrative costs that end up getting passed on to groups and members.

- **Section 4(1). Requires coverage for drugs that have been approved by others without requiring utilization review.**

  HB 4102 requires a prior authorization determination to be binding on the insurer if obtained up to 60 days prior to the service. This change to the existing 30 day standards means that insurers would potentially be required to cover additional medications that do not meet their utilization management criteria. This change is most challenging when members move from one plan to another and when a prior authorization from the original plan does not meet the same utilization standards of the plan the member is moving to. This change can result in increased costs for payers and the carrier which may have very little supporting rationale justifying the cost.

For these reasons, Moda Health opposes passage of HB 4102. We are committed to working with this bill's proponents to identify reasonable and consensus-driven language that addresses the concerns we have raised.

Sincerely,

Robert Judge
Director, Pharmacy Services