KAISER PERMANENTE®

March 3, 2021

The Honorable Deb Patterson Chair, Senate Committee on Health Care
900 Court St. NE
Salem OR 97301

RE: Opposition to SB 457

Dear Chair Patterson and members of the Senate Committee on Health Care,

Kaiser Permanente is respectfully but strongly opposed to Senate Bill 457, which would establish a standardized, statewide, outpatient drug formulary for all managed care plans participating in the Oregon Health Plan (OHP) as well as limit the ability of CCOs to prior authorize certain categories of prescription drugs. It also proposed troubling changes to the Health Evidence Review Commission (HERC) which would jeopardize its ability to develop evidence-based health care guidelines and conduct comparative effectiveness research that all providers, consumers and purchasers of health care in Oregon benefit from.

Kaiser Permanente is proud to participate in the OHP, where we serve as a fully delegated health plan through our partnership with Health Share of Oregon and PacificCare. We consider it part of our mission to participate in this critical public program, where we care for 60,000 residents in six counties.

Concerns about statewide formulary

Continuity and Equity in Care Delivery for All Members is Paramount at Kaiser Permanente: OHP enrollees who are Kaiser Permanente members benefit from the high quality and coordinated care that is available to all our members. Our philosophy is that all of our members have access to our integrated delivery system, regardless of payer. Our commercial members and our public members have access to the same network of top-notch physicians and hospitals, benefit from our superb electronic medical records system, and can utilize kp.org to track their medical information and manage their care.

This proposal raises serious equity issues by requiring us to have a different formulary for our OHP enrollees. Our Permanente physicians and other prescribers currently rely primarily on KP's own formulary to help them prescribe the most appropriate medications for their patients. Our prescribers have great confidence in KP's formulary, as demonstrated by our notably high formulary adherence rates, because they know it is developed by their own Permanente colleagues, working in partnership with pharmacists.

Medications are included on KP's formulary based first on a careful evaluation of the evidence regarding relative efficacy of drugs within a class, with drug prices considered only when available evidence does not clearly indicate the clinical superiority of one drug in a class over competing choices.

Drugs are placed on the KP formulary based on their efficacy and safety. Not only is this good medicine but choosing the most efficacious drug the first time reduces downstream costs by ensuring positive outcomes, minimizing extra visits to the doctor or hospital and eliminating prescription change costs.

Medicaid Single-PDLs May Have the Unintended Consequence of Increasing Drug Costs for Other Payers: Supplemental rebate agreements allow states to negotiate additional rebates with pharmaceutical companies beyond the rebates already required under the federal Medicaid Drug Rebate Program (MDRP). Nearly all states use PDLs that list preferred drugs not subject to prior authorization. Pharmaceutical companies are often willing to pay the state a supplemental rebate to ensure their product makes it onto the preferred list and would almost certainly pay higher rebates to ensure their products are not excluded from Medicaid.

Kaiser Permanente is concerned that further movement toward statewide formularies or uniform PDLs, if done in an overly rigid manner, could impede our ability to negotiate productively with pharmaceutical companies. State requirements that give preferential treatment to brand-name products threaten the remarkably high generic penetration we achieve on our formulary, forcing us to utilize more expensive drugs even though we are not able to get the same discounts the state gets through supplemental rebates. Such an approach would also hamper our overall ability to negotiate discounts with pharmaceutical companies. Our ability to negotiate deeper discounts is closely connected to utilization patterns for the drugs on our formulary. Changes in utilization caused by state requirements could have a direct, negative impact on our ability to purchase drugs at the most affordable price for our members.

Some states, including Washington, have also sought to impose statewide formularies or "uniform" PDLs on Medicaid Managed Care Organizations (MCOs) as a mechanism to drive-up supplemental rebates even further. These state policies require MCOs to adopt the state's formulary or requirements for designating preferred and non-preferred drugs. These policies could have the unintended consequence of increasing utilization of brand-name products with higher rebate potential at the expense of lower-cost alternatives and generics. MCOs and their enrollees also do not share in the cost-savings from supplemental rebates provided to the state. As a result, MCOs may have to give preferential treatment to drugs that will be more expensive for our members; this also creates an environment where providers are unable to prescribe the most appropriate drug for their patients.

Based on our experience in Washington, we believe that the statewide formulary proposal will inappropriately drive up utilization of brand name drugs in our heavily generic-based formularies and significantly increase costs without a medical rational to make such a change.

Concerns about proposed changes to the HERC

Sections 9 – 12 make changes to the Health Evidence Review Commission that are very troubling. Section 10 excludes drugs from the definition of "medical technology," which are subject to comparative effectiveness research and medical technology assessments while

Section 11 appears to only allow assessment of prescription drugs in the context of broader reviews. It is unclear what the rational is to limit HERCs ability to review prescription drugs. The Food and Drug Administration (FDA) does not generally require comparison to the standard of care for new drug approvals. Instead, drugs are often tested against a placebo in trials. Furthermore, numerous drugs are coming to market, particularly those approved through the FDA's accelerated pathway, based on very limited evidence and small trials. Limiting the HERC's ability to consider comparative effectiveness research and generate more evidence about these drugs makes no sense unless the goal is to hide the evidence and blind the state to higher cost, less efficacious drugs. Comparative effectiveness research at the state level is essential to ensuring that the prioritized list includes the most effective drugs and to support clinician-patient decision-making.

In sum, we believe that the policies envisioned in Senate Bill 457 would disrupt care, result in disparities for OHP members, and needlessly increase costs by shifting drug use from generics to brand name products. Please vote no on SB 457.

Sincerely,

Amy Fauver
Director, Government Relations
Kaiser Permanente