May 3, 2023

The Honorable Julie Fahey, Chair
House Committee on Rules
Oregon House of Representatives
900 Court St NE
Salem, OR 97301

RE: House Bill 3013 - Opposed

Dear Representative Fahey:

Moda Health Plan (Moda) presents this letter in opposition to the Dash 2 for House Bill 3013, a bill that would change how pharmacy benefit managers (PBMs) operate to serve Oregonians. This bill would make it much more difficult for carriers to run effective prescription drug benefit programs and would lead to higher health care costs for employers and consumer in Oregon.

Moda is a Northwest-based health insurer providing dental, medical and pharmacy insurance and administrative services in Oregon, Washington, Alaska, Idaho, Texas and Nevada. We deploy a range of clinical and pharmacy cost management services and strategies on behalf of more than 1 million individuals in the Pacific Northwest and beyond. Moda also administers the Oregon Prescription Drug Program on behalf of the Oregon Health Authority, which includes over 230,000 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 20,000 underinsured and uninsured residents who benefit from the preferential drug prices that the ArrayRx discount card offered by the state to residents has made possible.

Moda's concerns with HB 3013, as it would be amended, lie principally with Sections 4 and 7 of the proposed Bill. But there are other significant issues with the legislation as drafted that require reconsideration. Listed below are the major issues with the Dash 2 version of this Bill, followed by a brief summary of other sections that are bad for Oregon payers and our members.

- **Sec. 4 (1) and (2) by mandating changes to how pharmacies are reimbursed for medications they dispense would have a significant fiscal impact.**

  While this section seems intended to address the concerns of small chains and independents, it will apply to all pharmacies and will (1) increase pharmacy claims costs for payers and consumers; as well as (2) increase the administrative burden and PBM administration costs for payors.

  The bill would prohibit use of the industry standard benchmark Average Wholesale Price (AWP), which is the published list price for a drug sold by wholesalers to retail pharmacies. It would instead replace AWP-based reimbursement with reimbursement based on the OR Average Actual Acquisition Cost (AAAC), which is a narrow reference price developed by the Oregon Health Authority. AAAC is not comprehensive in terms of the drugs that are reflected in AAAC, nor are the surveys that are conducted that solicit wholesale invoice prices from

survey respondents all-inclusive. Also, studies have shown that AWP-based reimbursement is more cost effective for payers (employers and consumers) than AAAC-based reimbursement.

The bill would increase the administrative burden on PBMs associated with establishing network guarantees in contracts with payers, since the bill will require that PBMs maintain additional networks and guarantees and pay pharmacies in Oregon differently using a dispensing fee established by the Oregon Health Authority. Using today's dispense fees that OHA has in place will cause a shift in monies from payers and consumers to pharmacies, many of whom are not headquartered in this state.

As one example, Moda estimates that these changes could increase prescription drug costs ~1% or ~$1 million just for the OEBB plans Moda provides. It would have a similar impact across Moda's entire book of business in Oregon and would also affect every other health insurance carrier and self-insured employer group with members in Oregon. In addition, this Bill would raise prescription drug costs for consumers who use prescription drug discount cards that are processed through PBMs. Today, roughly 5.5% of all prescription drugs are paid for using a discount card, meaning Oregon consumers would see their pharmacy costs increase.

- **Sec. 4 (8) would shift ultimate appeal authority for network administration and adjudication decisions from PBMs and assign it to DCBS.**

  This would be a significant and inefficient breach of the methods that have been put in place by the Oregon legislature to provide a vehicle for reimbursement determinations to be appealed and resolved. It would place with DCBS, which has no knowledge, experience, capability or capacity to make determinations on reimbursements based on national trends within the pharmaceutical supply chain, the ultimate responsibility for arbitrating drug reimbursements for medications in the supply chain. To stand up this capability within DCBS would require a significant state investment that would add to the fiscal impact of this Bill and would likely result in wrong decisions on appeals being made.

- **Sec. 7 would limit PBMs' ability to audit pharmacies.**

  Section 7 changes would have a significant and consequential impact on ensuring a pharmacy is correctly submitting claims for payment. Audits help ensure claims for prescribed medications are correctly submitted by pharmacies in order to avoid incorrect and avoidable plan cost increases (e.g., dispensing expensive name-brand products when generics are readily available, non-adherence to quantity limits being submitted, mislabeled days supply entries, or, worse, fraudulently submitted claims).

  The language in this Section would create the following limitations on performing pharmacy audits:
  - <u>Limit the look-back period for audit to 6 months</u>. This provision would remove a critical element required to identify potential fraud as it would allow only a narrow window to be evaluated in order to identify potential fraud, which typically requires a more expansive review over time.

- Limit the audit to only reviewing 250 unique prescriptions in a 12-month period. According to data from Cardinal Health, a national drug wholesale distributor, a typical independent community pharmacy dispenses an average of 185 per day. Limiting an audit to 250 prescriptions per year results in less than 0.05% of the average prescriptions dispensed by an independent pharmacy being available for review. This is a statistically invalid limitation to ensuring that claims are being correctly entered and processed for payment. The limitation would be even less valid when applied to chain and regional pharmacies which dispense a greater volume of claims per day.
- Limit a pharmacy audit to no more than a single time in a 12-month period. This limitation removes from review pharmacies that have high volume claim activity or that dispense expensive medications, which are important areas to evaluate in order to identify areas for potential error or fraud. Combined with the other look-back changes, this means that incorrectly submitted high cost or Specialty claims may never be identified and result in higher costs to payers.

In addition to these principal concerns with this Dash 2 amendment, we also have the following concerns with these other sections:

- **Sec. 2 and Sec. 3 require pharmacy benefit managers to be licensed and subject to review and oversight and termination by DCBS.**

  These sections would change the oversight of PBMs from entities that must *register* with DCBS to entities that would be required to be *licensed* by DCBS. These sections also establish additional controls by DCBS over PBM licensure. As a result, PBMs would likely face increased costs (fees, fines, etc.) and risks and uncertainties (future rule changes, etc.) which would be passed on to Oregon carriers and employers.

- **Sec. 5 (2) (f) (B) through (E) would change how PBMs manage networks of pharmacies.**

  While these provisions contain language that sounds appealing, the changes may create a tremendous amount of disruption in the industry as they seem to green-light the ability of retail pharmacies to challenge or interfere with PBMs' responsibility to administer networks to achieve the best price management for clients they serve.

- **Sec. 5 (2) (g) would force PBMs to provide claims adjudication services for free to pharmacies.**

  The claims adjudication platforms that are created by PBMs are system assets and are necessary to affirm and calculate the member and payer cost of a prescription drug given the member's pharmacy benefit. The language in this Section would allow unfettered access by pharmacies to these platforms for price checks, eligibility checks, or other investigations and not solely for their intended purpose, to submit a claim for approval so it can be dispensed. By including this language, the Bill will allow pharmacies free access to a system resource and prohibit a PBM from being able to collect an access charge. Many PBMs (but not all of them) assess these charges today.

- **Sec. 8 (2) (c) and (d) would limit the ability of a payer to administer a pharmacy network that can ensure member convenience and lower costs.**

  The effect of the language on this section would remove the ability for a payer or plan to administer preferred or exclusive pharmacies in its network. This is an important tool to ensure that members can benefit from the convenience of mail order pharmacies and be confident in the quality of care from pharmacies that are expert in specialty drug medication delivery and use. It would remove a payer's ability to ensure that strict standards are maintained by the pharmacies that it chooses to participate in its network.

  Both provisions in Sec. 8 would inhibit PBMs' and payers' ability to manage pharmacy networks and would result in increased costs for payers. Payers would have no ability to identify specific pharmacy networks for their members. For example, this section could limit the ability of integrated health systems to leverage their access to lower cost medication for their system employees and beneficiaries. The net result would be high costs for those health system beneficiaries.

- **Sec. 9 (2) (e) through (h) would change how PBMs manage pharmacy claims that may qualify for 340B pricing.**

  These provisions would complicate management of claims that may qualify for 340B pricing and would increase risk for payers, PBMs, and manufacturers.

For these reasons, Moda Health opposes passage of HB 3013 as it would be amended. 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
Chief Client Officer, Pharmacy Solutions