May 4, 2023

Chair Fahey and Members of the Committee,

My name is Mary Anne Cooper, and I am the Oregon Director of Public Affairs and Government Relations at Cambia Health Solutions, which operates Regence Blue Cross Blue Shield of Oregon. We provide high value healthcare to nearly one million Oregonians. In keeping with our values as a tax paying nonprofit, 85% of every premium dollar goes to pay our members' medical claims and expenses. We are writing to express concerns about the impact of HB 3013 and the -2 amendment on consumer prescription drug costs.

We want to start by expressing that we understand and want to help solve the reimbursement issues raised by the pharmacists in earlier hearings on HB 3013. As a non-profit insurer, Regence contracts with Prime Therapeutics, a PBM that is owned by several Blue Cross Blue Shield plans, including Cambia. We contract with Prime to achieve the best drug price for our members and to ensure that we have a robust network of pharmacies available to our members.

Prescription drug spending is a significant driver of healthcare costs for Oregonians, and HB 3013 would exacerbate that trend. In Oregon, **prescription drugs account for 20-30% of all plan spending**.[1] Regence has seen its drug spending rise in recent years, from $90 per member per month in January 2022 to $110 per member per month in February 2023, with a total increase in our fully insured business of $29 million in one year. Oregon's Cost Growth Target report, released this week, noted that "while spending declined in many categories between 2019 and 2020 because of the COVID-19 pandemic, retail pharmacy spending increased 3.2% even after pharmacy rebates were taken into consideration. **Retail pharmacy has been consistently identified as a primary driver of health care cost growth in Oregon**."[2] The report also found that the high cost of health care is a barrier to access to health care for Oregonians, and that health care and health insurance represented 23% of all household spending. HB 3013 and the -2 amendment would unquestionably exacerbate both these trends.

Section 4(2)(i) of the -2 amendment appears to require PBMs to pay a dispensing fee established by OHA by rule and reimburse drug costs by setting the fee-for-service (FFS) Medicaid rate as the floor, with the lesser of a number of methods as the ceiling. While it is not clear that the bill is codifying the FFS Medicaid dispending fee, it appears that is what is intended by the reference to the OHA

[1] Department of Consumer and Business Services. (2022, November 30). Prescription Drug Price Transparency Results and Recommendations – 2022. Retrieved March 9, 2023, from https://dfr.oregon.gov/drugtransparency/Documents/Prescription-Drug-Price-Transparency-Annual-Report-2021.pdf

[2] New OHA report details health care spending trends (govdelivery.com)

rule. The FFS Medicaid dispensing fees are based on a pharmacy's total annual claims volume, as determined by the claims volume survey process. Dispensing fee tiers are as follows:

* Less than 29,999 claims a year = $14.01
* Between 30,000 and 49,999 claims per year = $10.14
* 50,000 or more claims per year = $9.68

Here is a link to the OHA website<https://www.oregon.gov/oha/hsd/ohp/pages/aaac-rates.aspx>.

By comparison, the current dispensing fees paid by PBMs are much lower than that, which we understand to be part of the concern of the pharmacists and which we are willing to address. However, the dispensing fee increase could be as much as 60x higher than current rates with the -2 amendment.

- This cost will be passed onto all commercially insured Oregonians in their premiums and will be felt acutely by consumers as a result of higher out-of-pocket prescription costs (which they will pay directly through their co-pays, co-insurance and deductibles)
- Also note that 90% of prescriptions are generics and consumers often pay the usual and customary (U&C) price instead of their copay because it is the lesser of the two. So, a significant number of generic prescriptions will move from low-cost U&C prices to full insurance copays/cost-shares as a result of this proposed change.

Today, 60% of our members are paying less than their benefit defined copay/cost-share levels because of lower cost generic drugs. We recognize the current complexity in drug price reimbursements. However, a mandated change in reimbursement requirements has a direct unintended consequence of immediately raising the out-of-pocket costs for Oregonians. A similar dispensing fee increase in Tennessee is resulting in significant impacts to consumers, with a recent article noting that some consumers were preparing to cut back on live saving medications as a result of the increase.[3]

By way of a personal example, I currently get three fairly low-cost prescriptions filled monthly, all generic. The total cost of my prescriptions are paid by me (via my HSA) because I almost never hit my deductible. If my pharmacy started charging a $14 dispensing fee for each medication, my presently low-cost prescriptions would suddenly become an expensive monthly cost (with the dispensing fee jumping from an average of a dollar per month to $42 for the three medications). This is in addition to a premium increase, reflecting significant cumulative costs to be absorbed by insurance with changes to dispensing and reimbursement fees. While I could handle these cost increases and have an HSA available to help me pay, many Oregonians do not, and this bill will have significant negative impacts to affordability for them.

[3] Tennesseans feel hit of prescription drug price hike - Claiborne Progress | Claiborne Progress: https://www.claiborneprogress.net/2023/01/25/tennesseans-feel-hit-of-prescription-drug-price-hike/#:~:text=The%20new%20law%2C%20which%20took%20effect%20on%20January,to%20%2411.98%20for%20prescriptions%20filled%20at%20independent%20pharmacies.

Additionally, our preliminary modeling shows us that this will have a significant fiscal impact, both directly and indirectly, for our members.

- We estimate that compliance with the bill would cost an additional $1.33 million per month in dispensing fees, approximately $27,000 a month for brand name price increases for reimbursement, and significant decreases in generic reimbursement rates (which would work to help offset the dispensing fee increase cumulatively).
- Although we estimate that lower generic reimbursement rates will neutralize the increased dispensing fees (using the state's average acquisition cost) for the plan, adding a higher and fixed dispensing fee between $9.68 to $14.01 will increase costs at the pharmacy counter for approximately 70% of our members (via generic drug copays and brand drug cost-shares). Some members will see a 170% cost increase on prescription drug claims directly.

On the other hand, pharmacies have not demonstrated that a 60x increase to dispensing fees in addition to their proposed reimbursement rate changes is needed to make them "whole". We are greatly concerned that this formula goes far beyond what is needed to ensure pharmacies operate in the black, at the ultimate expense of consumers.

We would encourage that instead of locking a formula into statute, <u>you instead direct a process whereby DFR will set a rate formula by rule with sideboards that help direct what factors should be considered to ensure that pharmacies receive a reasonable cost recovery while minimizing unnecessary cost increases for plan participants</u>. We are happy to provide suggested language for this approach.

We also believe that the bill should contain language that disallows exclusive wholesale contracts, enabling pharmacies to shop around where they can. Exclusive wholesale contracts also add difficulty in the ability of pharmacies to appeal reimbursements. Removing this barrier will increase the ease at which pharmacies can work with insurers to obtain appropriate payment of claims.

We are committed to resolving the problem faced by the pharmacies to ensure they are viable, but want to be clear that as drafted, the bill is going to cause significant cost increases for consumers both at the pharmacy counter <u>and</u> in their premiums, and may provide a windfall to pharmacies in the commercial insurance space.

We also would like the bill to address the following remaining issues:

- <u>Any willing pharmacy</u>: We also continue to be concerned with the any willing pharmacy language in the base bill (page 8, line 39) that states that an insurer "may not deny a pharmacy or pharmacist licensed in this state the opportunity to participate as a preferred provider or a contracting provider, under the same terms and conditions applicable to all other preferred or contracting providers if the pharmacy or pharmacist agrees to the terms and conditions." As insurers, we have an obligation to our members to ensure that any business in our network can provide safe and competent service, and will be a good

participant in a network. There are a myriad of reasons that an insurer may deny access to our network, including consumer complaints, poor compliance history, licensing issues etc. We should not be required to contract with a pharmacy that we have concerns about. *If this language remains, it will be important to carve out specialty pharmacies – they are not the types of pharmacies that are targeted by the bill, and contracts with specialty pharmacies are one of the few ways insurers can control costs on very expensive specialty drugs not administered or available in retail pharmacies.

- ERISA: The bill also seeks to regulate self-insured plans on Page 2, line 23. We believe any regulation of self-funded plans to be preempted under ERISA. Of course, ERISA preemption ultimately is a determination a court must make. We ask that any application of the bill to self-funded plans be removed to avoid the likely protracted disputes that could arise from legal challenges that would be costly for all involved.
- Effective Date: Given the magnitude of changes proposed in the legislation, PBMs would have significant hurdles in implementing in 2024, especially given that plans are already in the process of filing rates for 2024. We would request that the bill have an effective date of 2026 to ensure that there is adequate time to develop new systems and account for rate impacts.

Thank you for your consideration, and please let me know if you have any questions.

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