Tuesday, February 6, 2024
Testimony before the House Committee on Behavioral Health and Health Care

HB 4012 Prohibits requiring drugs be dispensed by network specialty pharmacies

Rep Rob Nosse, Chair; Rep Christine Goodwin, Vice- Chair and esteemed committee members:

My name is Michael Millard, Legislative Co-Chair of the Oregon Society of Health-System Pharmacists, representing pharmacists and technicians working in organized health systems in Oregon to advance the practice of pharmacy and assure that Oregon is a model of excellence in health-system pharmacy.

OSHP supports HB 4012, especially the provisions found in Section 2 (1)(2) of the bill. OSHP does not support the unnecessary subsection (3). We would propose more complete and specific language as proposed in the last legislative session in HB 2715

Most provider-administered outpatient drugs are governed by the buy-and-bill process. In the buy-and-bill process, a healthcare provider purchases, stores, and then administers the product to a patient. After the patient receives the drug and any other medical care, the provider submits a claim for reimbursement to a third-party payer. The process is called buy-and-bill because the medical claim is submitted (billed) after the provider purchases (buys)and administers the drug.

Third-party payers have therefore created or mandated a role for specialty pharmacies in managing and distributing provider-administered specialty drugs. There are several alternative approaches:

- White bagging. A specialty pharmacy ships a patient's prescription directly to the provider, such as a physician office or an outpatient clinic. The provider holds the product until the patient arrives for treatment.
- Brown bagging. The patient picks up a prescription at a pharmacy and then takes the drug to the provider's office for administration.

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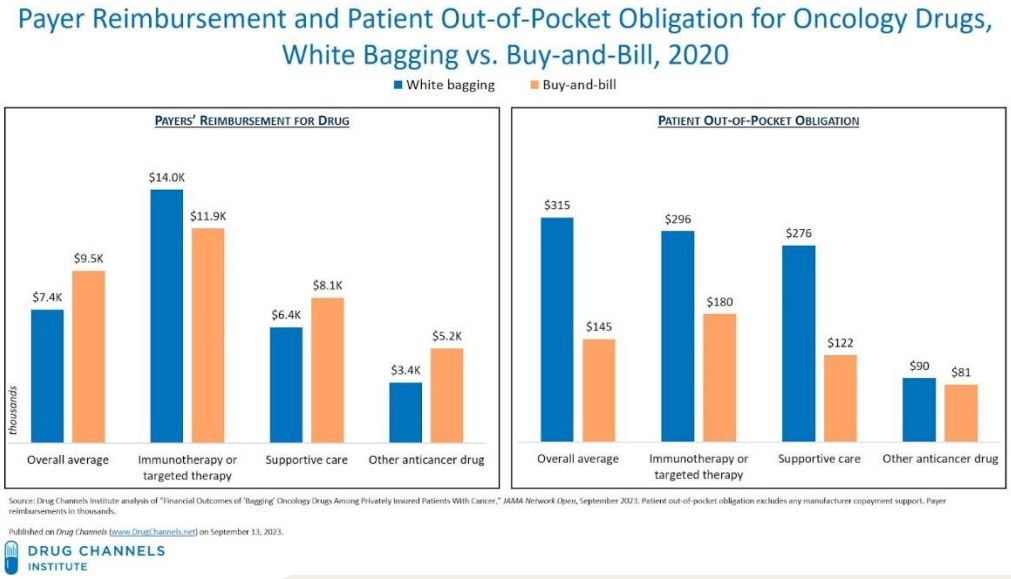
With any of these approaches, the provider neither purchases the drug nor seeks drug reimbursement from a third-party payer. Instead, the specialty pharmacy adjudicates the claim and collects any copayment or coinsurance from the patient before treatment. However, the provider is still paid for professional services associated with the drug's administration. Providers are not permitted to bill the third-party payer for drugs, because the pharmacy receives the reimbursement for the drugs sent to the provider.

Patients lose out. An intriguing new JAMA Network Open study found that white bagging lowered payers' costs but raised patients' out-of-pocket obligation. (See Financial Outcomes of "Bagging" Oncology Drugs Among Privately Insured Patients with Cancer.) link Overall average payer reimbursements were more than $2,000 lower when oncology drugs were white bagged by pharmacies compared with provider payments under buy-and-bill. However, patient obligations were always higher when products were white bagged compared with buy-and bill. White bagged products are typically billed under pharmacy benefit plans, where patients face coinsurance and deductibles for specialty drugs. By contrast, many commercial plans require no or minimal patient cost sharing for drugs administered in a hospital outpatient setting and billed to the medical benefit.



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The Oregon Society of Health-System Pharmacists (OSHP) Legal and Regulatory Affairs Committee (LRAC) is presenting a reworked 2023 HB 2715 in the 2024 short session to prevent the practice of "White Bagging" in Oregon.

We want to prevent the process where payers decide to use self-owned pharmacies to send physician-administered medication directly to clinics to force patient administration of their drug. This practice bypasses the safety processes of the clinic institution by forcing them to prepare and use medication which they do not control. The payer and their pharmacy then keep the medication revenue. This is especially dangerous for the patient because it bypasses a pharmacist safety evaluation and supply chain integrity. The healthcare professionals who interact and deliver the necessary, lifesaving treatments, not health insurers, should choose where they obtain drugs to ensure supply chain integrity, accurate medication dose, and to avoid delays of necessary and lifesaving treatments.

The suggested language for section 2 of the bill would include patient and physician protections to insure choice for the best health outcomes.

> ***(b) A health benefit issuer shall not:***
> *(1) refuse to authorize, approve, or pay a participating provider for providing covered clinician-administered drugs and related services to covered persons.*
> *(2) impose coverage or benefits limitations, or require an enrollee to pay an additional fee, higher copay, higher coinsurance, second copay, second coinsurance, or other penalty when obtaining clinician-administered drugs from a health care provider authorized under the laws of this state to administer clinician-administered drugs, or a pharmacy.*
> *(3) interfere with the patient's right to choose to obtain a clinician administered drug from their provider or pharmacy of choice, including inducement, steering, or offering financial or other incentives.*
> *(4) require clinician-administered drugs to be dispensed by a pharmacy selected by the health plan.*
> *(5) limit or exclude coverage for a clinician-administered drug when not dispensed by a pharmacy selected by the health plan if such drug would otherwise be covered.*
> *(6) reimburse at a lesser amount clinician-administered drugs dispensed by a pharmacy not selected by the health plan.*
> *(7) condition, deny, restrict, refuse to authorize, or approve, or reduce payment to a participating provider for providing covered clinician-administered drugs and related*

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services to covered persons when all criteria for medical necessity are met, because the participating provider obtains clinician-administered drugs from a pharmacy that is not a participating provider in the health benefit issuer's network.
(8) require that an enrollee pay an additional fee, higher copay, higher coinsurance, second copay, second coinsurance, or any other form of price increase for clinician-administered drugs when not dispensed by a pharmacy selected by the health plan.
(9) require a specialty pharmacy to dispense a clinician-administered medication directly to a patient with the intention that the patient will transport the medication to a healthcare provider for administration

These provisions would:

- Allow physicians who treat the patients to choose where they obtain the clinician-administered medications.
- Offer patients the choice to choose where to be treated, based on cost.
- Reduce the risk of medication spoilage during delivery.
- Minimize unnecessary additional patient visits due to supply chain errors.
- Allows health care providers to adapt therapy based on the patient's most recent labs.
- Reduce medication waste.

OSHP strongly supports HB 4012 and hopes the committee will consider amendments to further strengthen its protections for patient and physician choice.

I have included some supportive information from the American Society of Health-system Pharmacists and some similar legislation in other states for your review.

Sincerely, on behalf of OSHP,

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Legislative Co Chair OSHP Legal and Regulatory Affairs Committee.

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