Tuesday, February 4,2025
Statement before the House Committee on Behavioral Health and Health Care

HB2011 Prohibits requiring drugs be dispensed by network specialty pharmacies

Rep Rob Nosse, Chair; Rep Cyrus Javadi and Rep Travis Nelson Vice- Chairs 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 2011. 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.

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"

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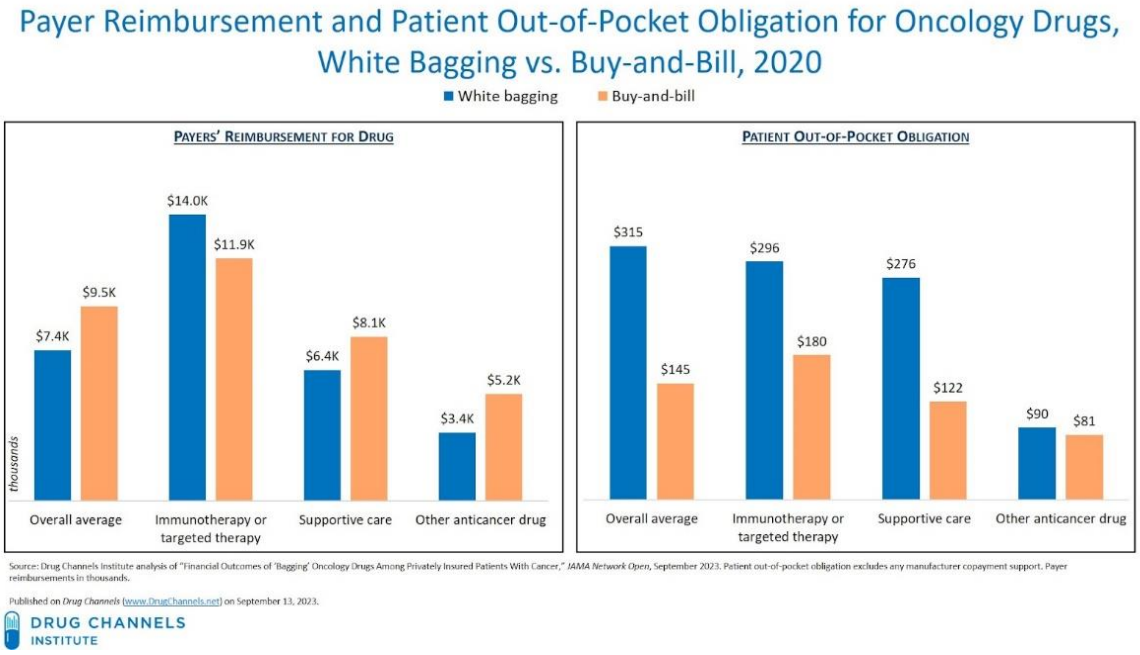
Oncology Drugs Among Privately Insured Patients with Cancer.) link Overall average payer reimbursements were more than $2,000 lower when oncology drugs were white bagged by pharmacies compared with provider payments under buy-and-bill. However, patient obligations were always higher when products were 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.



White Bagging is a practice that allows the PBM to keep the revenue, rebates and other income from the medication in its opaque profit-making business and transfers the cost of the medication to the pharmacy benefit copays and deductibles for the patients.

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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. 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. Sometimes the dose or drug will need to be changed on the day of therapy, wasting the drug that was "white-bagged".

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.
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OSHP and OAHHS urge the passage of this legislation in order to protect medication supply chain integrity and patient safety. Since 2021, 24 states have introduced similar legislation to restrict or prohibit payer-mandated white bagging, and 7 states have enacted the laws fully (VT, TN, LA, AR, VA, WV, NE). OSHP strongly supports HB 2011 and hopes the committee will approve this bill and recommend passage 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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