PacificSource
HEALTH PLANS

February 20, 2025

Representative Rob Nosse, Chair
Representative Cyrus Javadi, Vice-Chair
Representative Travis Nelson, Vice-Chair
House Committee on Behavioral Health and Health Care
Oregon Legislative Assembly
900 Court St. NE
Salem, OR 97309

Re: Opposition to House Bill 2011, Related to Site-Specific Payments for Physician Administered Medications

Chair Nosse, Vice-Chairs Javadi and Nelson, and Members of the Committee:

The PacificSource companies are independent, not-for-profit health insurance providers based in Oregon. We serve over 600,000 commercial, Medicaid, and Medicare Advantage members in three states. PacificSource Community Solutions is the contracted coordinated care organization (CCO) in Central Oregon, the Columbia River Gorge, Marion & Polk Counties, and Lane County. Our mission is to provide better health, better care, and better value to the people and communities we serve.

We write today as a smaller, not-for-profit plan that does not own a specialty pharmacy or a pharmacy benefit manager to oppose House Bill 2011, which prohibits health plans from denying or restricting coverage of physician administered drugs obtained by providers, including hospital outpatient departments.

Testimony on the record characterizes this bill as addressing the practice of “whitebagging,” where a specialty pharmacy delivers a prescribed medication directly to a healthcare provider for administration to a patient. But a comparison of the text of this bill with the introduced version of House Bill 4012 (2024) tells us that this legislation is preemptively protecting providers from federal movement in Medicare toward site-neutral payments.

Currently, Medicare pays more for services that are rendered in a hospital than for the same services rendered in freestanding settings, like independent infusion centers. Policymakers have expressed concern that the Medicare system is paying more for no discernable improvements in the quality of care and have attempted to address the disparity. The federal House of Representatives passed H.R.5378 in December 2023; this bill would have included site neutral payments for drug administration services under Medicare Part B. In a letter to congressional leadership on the bill, the Alliance for Site Neutral Payment Reform notes that "put simply, if a service is provided safely in the lower-cost physician office setting, there is no reason that patients or taxpayers should be paying 2-3x more for the exact same service in the

[hospital outpatient department] setting."[1] In June 2024, the Medicare Payment Advisory Committee, a body of physicians that advises Congress on Medicare policy, also released a report that recommended site neutral payments for low-complexity medical services like drug injections.[2] These reforms would follow Medicaid in Oregon; the Oregon Health Authority fee schedule for fee-for-service Medicaid, which coordinated care organizations look to as a model for contracting, does not add a differential for site of care.

With this context in mind, we oppose this bill for the following reasons.

First, this bill would remove any ability to ensure the 23% of Oregonians covered by private health plans receive infusions and other administered drugs in clinically appropriate but alternative, lower-cost settings. This bill applies to a wide range of providers – in particular, hospital outpatient departments. Hospital outpatient departments can be the product of vertical integration between hospitals and independent physician practices.[3] Hospital outpatient departments tend to charge higher prices for the same services as freestanding services.

From our own data, one of our members needs infusions of a drug called nexviazyme, a treatment for late-onset Pompe disease. The member receives infusions at a hospital; the rates charged by that system are 371% of the average sales price.[4] Infusions at a preferred infusion partner site would charge 110% of the average sales price. In a dollar sense, while we could pay $888,000 for infusions, we pay $3 million for the infusions. This is a particularly egregious example, but we fear that this outlier will become the norm if this bill passes.

We remain unclear if this bill applies to oncology clinics, which the Assembly already addressed in House Bill 4012 (2024). Technically, the definition of provider would include oncology clinics. Testimony indicates that one of the chief concerns of proponents is chemotherapy, which we believe would be covered by existing legislation. This bill does include an exemption for centers of excellence, which are specialized programs that supply concentrations of expertise and resources toward a specific medical area. They can include cancer care, but are not limited to them. Centers of excellence tend to be found in hospital settings and can be the subject of negotiated agreements between hospitals and payers. For instance, we negotiated a cancer center of excellence with a regional hospital to complete contract negotiations in 2023.[5]

We can envision a scenario where the only real alternative to paying high markups to hospitals for physician administered drugs is to enter negotiations with them to help stand up centers of excellence. Negotiating in these conditions is not a true arm's length negotiation in any sense of the word, and unfairly leverages state law to gain an advantage in negotiations.

Next, unclear and contradictory language will complicate implementation of this bill, should the Assembly agree with the underlying policy argument. For example, subsection (2) of the bill prohibits health plans from, "in any way," restricting coverage for physician administered drugs. But subsection (3) of the bill defines what restricting coverage means, as one of four broad categories of action. Does the bill really mean we cannot restrict in any way coverage, or does "any way" just mean the itemized list of actions? What if the broad prohibition and the itemized list conflict? We will presume the legislature was intentional about limiting the universe of what "any way" means, but these kinds of drafting inconsistencies will complicate post-passage implementation.

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[1] https://www.siteneutral.org/wp-content/uploads/2023/12/12062023-Alliance-letter-to-House-leadership-on-Site-Neutral-Payment-Reform_FINAL.pdf
[2] https://www.medpac.gov/wp-content/uploads/2024/06/Jun24_MedPAC_Report_To_Congress_SEC.pdf
[3] *See*, e.g., Richards, Michael R., Jonathan Seward, and Christopher M. Whaley, Treatment Consolidation After Vertical Integration: Evidence from Outpatient Procedure Markets, RAND Corporation, WRA621-1, 2020 (available at https://www.rand.org/pubs/working_papers/WRA621-1.html).
[4] ASP is a methodology used by Medicare which collects data from manufacturers of Medicare Part B covered drugs.
[5] https://stcharleshealthcare.org/news/st-charles-announces-agreement-pacificsource

Finally, this bill will make contracting exceedingly difficult. Should health plans find a way to make sure that members are receiving quality care with less cost, it is possible that any decision we make will subject us to a private right of action – even if we followed the bounds of the law. The cited portion of the Unlawful Trade Practices Act, ORS 646.608, allows private entities to file suit and, if they are able, certify a class of plaintiffs that can join (class-action suit). This is a punitive measure, even by the standards of the Insurance Code.

For those reasons, we respectfully oppose House Bill 2011. Thank you for your consideration of our concerns.

Sincerely,

/s

Richard Blackwell
Director, Oregon Government Relations