Regence | 200 SW Market Street, 11th Floor
Portland, OR 97201

Regence Testimony SB 598

March 11, 2025

Chair Patterson and Members of the Committee:

My name is Mary Anne Cooper, and I am the Director of Government Affairs at Regence BlueCross BlueShield of Oregon. As the state's first and largest commercial health insurer, Regence is committed to addressing both persistent and emerging health needs for the nearly one million Oregonians we serve. In keeping with our values as a tax-paying nonprofit, 89% of every premium dollar pays for our members' medical claims and expenses. We are here today to express concerns about SB 598 and the impact it would have on prescription drug costs.

Prescription drugs are currently one of the fastest growing costs for health insurers, and SB 598 would exacerbate that trend. Within Regence, our drug costs grew by $43 million between 2023 and 2024, and our per member per month overall drug spend increased from $110 to $125 in the same period. The 2024 Cost Growth Target Annual Report demonstrates that, net of rebates, retail pharmacy costs across all carriers increased 4% between 2021-2022, from $4.04 billion to $4.2 billion[1]. Without accounting for rebates, total growth in drug spend was 7.1%, which is higher than the percentage of growth of any other service category. Increases in utilization, new indications for existing drugs, and exorbitant prices of new drugs entering the market contribute to this year-over-year growth and already significantly impact members.

With prescription drug costs driving significant healthcare spending, utilization management (UM) is used judiciously based on a combination of evidence, standards of care, clinical guidelines, available alternatives, practical considerations and cost. Regence then regularly reviews and evaluates the necessity of UM programs to confirm they remain clinically

[1] *Sustainable Health Care Cost Growth Target 2024 Annual Report*. Oregon Health Authority : Sustainable Health Care Cost Growth Target : Office of Health Policy : State of Oregon. (2024). https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx

appropriate and cost-effective. For overall context however, it should be important to note less than 3% of all medicines have UM in place.

While we understand and agree with the intent of ensuring that non-opioid drugs are being prescribed where possible, and are not more challenging to obtain than opioids, this bill would result in significant cost increases without a clear path to improve the opioid epidemic. Generally, the standard of care for health care providers is to direct patients to safe and effective non-opioid pain relief instead of opioids due to the risk of addiction. Fortunately, the non-opioid space is crowded with affordable generics where plans do not have any UM. As such, the most common non-opioids prescribed by our local doctors are not more difficult to obtain than opioids.

The way we read the bill, it would require all non-opioids to be placed with parity on formularies and not have any step therapy or other requirements if they differ from the least restrictive UM on opioids. First, this is agnostic to branded me-too products, which is a major source of concern. The bill should exclude branded (including high-cost single source generic) products where low-cost generics already exist. However, the bill requires all non-opioids to be on formulary and tiered as preferred for insurers, even if they cost $1,000 a pill and are functionally the same as ibuprofen.

Excluded Drug	Cost	Alternative Rx Cost	Difference ($)	Difference (%)
Ketoprofen 50 mg (single-source generic)	$3013	$6	$927	50,116%
Sprix (ketorolac tromethamine)	$2,304	$11	$2,293	20,845%
Zipsor (diclofenac)	$1996	$12	$2,230	8,233%
Journavax (suzetrizine)	$1100 (estimate per mo)	$6	$1094	18,233%
Duexis (ibuprofen/famotidine)	$336	$12	$988	2,158%
Vimovo (naproxen/esomeprazole)	$2,681	$40	$2,641	6,602%

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Second, this will require employers and insurers to include novel high-cost drugs that may offer no significant safety or efficacy advantage over existing lower cost non-opioid alternatives, raising costs for all. Indeed, the fiscal note for a similar bill in Utah estimated that a new non-opioid drug would cost them 60 times ($18) more than non-opioids they currently cover ($0.30) but we estimate a much higher differential.

Generally, the standard of care for health care providers is to direct patients to safe and effective non-opioid pain relief instead of opioids due to the risk of addiction. However, all non-opioids are not created equal, and some have significant safety concerns that warrant close monitoring by both the health care practitioner and the insurer. For example, the drug Ketorolac (brand name Toradol) is a very effective non-opioid pain medicine used often for acute pain, but if you take it for more than five days it puts you at increased risk of heart and clotting issues, kidney failure, ulcers, and increased risk of bleeding. It is recommended that it not be used for longer than five days due to these serious issues.

When evidence between prescription drugs are equal, inadequate, or inferior, insurers will place drugs on their formulary and determine UM based on cost, often disadvantaging costly drugs that are not clinically superior to similar alternatives. As we read this bill, if there was a new non-opioid on the market where the evidence on effectiveness is not demonstrably better than commonly prescribed non-opioids (e.g., NSAIDs, Tylenol) but cost 183x as much, we would be required to provide parity coverage as other non-opioids treatment despite the fact that NSAIDs, Tylenol, or a combination of the two, are reasonable treatments for most patients at a fraction of the cost. This would both cause higher cost share for consumers at the pharmacy counter and increase premiums for all members.

Health plans currently have processes in place to ensure patients can access higher-cost medications when clinically necessary or reasonable. For instance, if a patient cannot take preferred non-opioid analgesics, there are clear pathways to access more costly products.

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This legislation would be precedent setting, bypassing these established processes. This creates a template for other manufacturers to demand similar preferential coverage. This also encourages manufacturers to create "new" branded versions of currently available NSAIDs or salicylates and those would inadvertently be forced for coverage at the same level of cost-sharing and copayment as lower-cost products in the same class. There are plenty of manufacturers that still price gouge on common drugs either by introducing a new "dose" formulation, tablet/capsule formulation of a generic drug but then go and charge high branded prices for those "new" products.

Several other states have seen similar legislation introduced this session, often supported by pharmaceutical manufacturers seeking to ensure coverage of their products. We are not aware of any versions of this bill that have moved forward in other states. The financial implications are significant. When health plans are required to cover higher-cost medications without the ability to implement standard UM, these costs directly impact premium rates. Small businesses and families ultimately absorb these increased healthcare costs through higher premiums.

While this bill is well intentioned, it will ultimately interfere with our ability to provide clinically appropriate UM programs designed to ensure evidenced-based and cost-effective use of non-opioid medicines.

Please do not hesitate to contact me with any questions.

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