February 4, 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 3212, Relating to Pharmacy Benefit Managers

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.

PacificSource does not own a stake in a pharmacy benefit manager (PBM), nor does a PBM own any part of PacificSource. Pharmacy benefits are complex, and drug manufacturers are large and sophisticated enough, that using the services of a PBM is a necessity.

We write to express our opposition to parts of House Bill 3212 – namely, the proposed changes to professional dispensing fees, and the requirement to contract with any willing pharmacy. We appreciate the chair's work to convene a workgroup in the summer of 2024 to highlight the important issues around pharmacy benefits.

First, in section 1(2)(n) of the bill, PBMs must pay “a professional dispensing fee in an amount no less than the dispensing fee established by the Oregon Health Authority by rule.” The bill remains quite vague as to how the Oregon Health Authority would determine the amount of this dispensing fee. The bill also does not provide any guidance for the agency in setting dispensing fees between lines of insurance. We have no reason to believe that the agency would intentionally limit dispensing fees in Medicaid but raise dispensing fees in commercial health plans, but nor are there constraints on the agency in the bill. The bill does not provide any limitations on the amount of the dispensing fee, either. In the fee-for-service program, the Authority used surveys of pharmacies to develop a state plan amendment submitted to the Centers for Medicare and Medicaid Services (CMS). If approved by CMS, the dispensing fees

for fee-for-service pharmacy benefits in Oregon would range from $9 per prescription to $16.88 per prescription, based on the volume of the pharmacy.[1]

In opposing changes to the dispensing fee provisions, our focus is on the member impact. We wish to highlight what we believe our membership will experience when filling prescriptions at the pharmacy counter, or in the case of government programs like the Oregon Health Plan, what the plan sponsor will ultimately bear. Insurance plans and managed Medicaid either build on their own or engage the services of PBMs to build drug formularies. These formularies are further divided into multiple tiers. Lower tiers have standard copay amounts, and are reflective of the low cost of the drug. At least for PacificSource health plan members, generics may be found on the second-lowest tier and have for health plan members a fixed cost share (e.g., $10). This fixed cost share covers dispensing fees, acquisition, and other costs.

Dispensing fees are supposed to represent the reasonable overhead costs the pharmacist. But as the amount of overhead increases, so too does the price of the prescription. As the prescription price increases, so too does a member's cost sharing or plan sponsor's responsibility.

For example, we cover a class of generic migraine medications called triptans on a low-level tier. Generic triptans have a fixed, $10 copay. If this bill is enacted, we would need to raise the cost sharing for this drug by the amount of the increased dispensing fee. This means our members (or plan sponsors) could pay $19 to $26.88, rather than the $10 they currently pay for this drug.[2]

People relying on lower-tier drugs are also more likely to have co-occurring conditions that require more than one prescription. Each prescription for which a person needs access will see an increase in the dispensing fee added to it, further adding the cost burden at the counter for health plan members or for the plan sponsor, in the case of government programs.

Unfortunately, asking parties to absorb these costs is not a practical option. PBMs will develop new forms of fees or reimbursement into their contracts with us. Furthermore, in determining insurance rates every year, the Insurance Commissioner must examine prescription drugs as part of the commissioner's overall review that rates are neither excessive nor inadequate.[3] The actuaries contracted with the Oregon Health Authority will have to engage in a similar process, factoring in the increases in professional dispensing fees as they look at cost trends from the prior rate-setting cycle in setting capitation for managed Medicaid plans.

In other words, these increased costs will have to be borne either by the state or by the purchasers of private insurance. This concern is not a purely academic exercise - in Idaho, a similar bill enacted in 2024 has resulted in significant, additional cost to health plans in the state. Our Idaho members are raising concern about prices at the counter, and we still have additional administrative fees to pay to our PBM on top of dispensing fee changes.

Unfortunately, one proffered reason for this increase in dispensing fees is that independent pharmacies are closing their doors, leaving pharmacy deserts in their wake. In the 2024 PBM workgroup, however, the state's Board of Pharmacy presented on licensing trends which showed that independent pharmacy licenses were relatively stable. According to the Board of Pharmacy, Oregon saw a net loss of 8 pharmacy licenses between 2016 and 2024 (126 licensed independent pharmacies to 118 licensed independent pharmacies). Chain pharmacies and health systems did not fare as well, suffering a net loss of 76 licensed locations in the same time period. Nonetheless, if the Assembly is ready to ask our members to pay marked increases

[1] https://www.oregon.gov/oha/HSD/Medicaid-Policy/StatePlans/24-0019.pdf
[2] Presuming that OHA rulemaking mirrors proposed fee-for-service rates.
[3] *See, e.g.,* ORS 743.108 (rate review process for commercial health plans)

at the pharmacy counter for prescription drugs, it needs a fuller picture of how those price hikes will directly ensure access to pharmacy care.

Next, section 1(2)(o) of the bill requires PBMs to reimburse in-network and out-of-network pharmacies in the same manner. The bill further goes on, in section 2(2)(i), to prohibit PBMs from denying pharmacies contracts if the pharmacy agrees to its terms and conditions. In other words, a PBM would not be able to enter into a contract with a health plan or a CCO like PacificSource that had any network controls built in.

Health plans and CCOs already have legal requirements to ensure that we contract with sufficient numbers of providers to cover the services that we provide, which is unique to any participant in the health care space.[4] Current law recognizes that as both an insurer and a CCO, we have to balance access with quality when making network decisions.

Under this bill, when constructing networks for insurers, the PBM would have to extend a contract to any pharmacist willing to sign the dotted line. We could not make any allowances for quality in our networks.

We think a better solution is a bill introduced in the Senate, SB 822 requested by the Department of Consumer and Business Services, around network adequacy. It would replace the factor-based approach in law since 2015 with factors more focused on time and distance and wait times. This approach would strike a better balance between access and quality.

Thank you for your consideration. Please do not hesitate to contact me at (541) 284-7736 or richard.blackwell@pacificsource.com if you have any questions or would like follow up information.

Sincerely,

/s

Richard Y. Blackwell
Director, Oregon Government Relations

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[4] *See* ORS 743B.505 (network adequacy for health benefit plans); ORS 414.609 (network adequacy for CCOs).