



Regulatory Affairs

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Jesse O'Brien
Senior Policy Analyst
Division of Financial Regulation
350 Winter Street NE
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VIA EMAIL: Jesse.E.Obrien@oregon.gov

RE: HB 4005 Rulemaking; Comments on proposed rule language

Dear Mr. O'Brien:

Thank you for the opportunity to provide comments on the draft rulemaking language required by passage of HB 4005 (2018). Cambia Health Solutions (Cambia) is a healthcare company deeply rooted in a 100-year legacy of transforming the industry and the way people experience health care. Our health plans cover over 700,000 members in Oregon and we are committed to working with the Division of Financial Regulation (Division) to draft rulemaking language in line with legislation passed that exposes the true out-of-pocket cost of prescription drugs on Oregon consumers.

OAR 836-200-0500 Definitions

The Division added a definition of "Net yearly increase" to describe how much a prescription drug increases annually to an Oregon consumer. We believe the definition as written is not reflective of the actual net increase and provides pharmaceutical manufacturers the opportunity to deceive consumers on the true net yearly increase. As written, the definition only offers a snapshot of a price on two specific dates of a calendar year (January 1 and December 31). A manufacturer could decrease prices on those two days to provide a much lower annual increase in their report than the actual true cost to the consumer. We support the AARP proposal submitted on October 22, to define the "net yearly increase" by using the average Wholesale Acquisition Cost (WAC) price over the course of a calendar year.

OAR 836-053-0473 Required Materials for Rate Filing for Individual or Small Employer Health Benefit Plans

In-Patient Medical Benefits: We strongly oppose the inclusion of in-patient medical benefits included in (2)(l)(a) in the proposed language requested by Providence Health Plans. This request exceeds the scope of the granting legislation in HB 4005 and will

not provide an accurate reflection of prescription drug costs to Oregon consumers. This proposal will require payors to list drugs given to members admitted to a hospital for care. Carriers are often unable to discern the specific quantity and cost of drug administered to a member due to complexities and lack of transparency in billing processes and codes used for inpatient claims. Inpatient facilities often bill these drugs as part of Diagnosis Related Groups (DRG) whereby carriers pay a fixed payment for the hospital stay, inclusive of the drugs administered. Outside of DRG payments, additional billing practices, including the use of non-specific coding, results in cumbersome, error-prone reporting. For example, the use revenue codes for payment will not define the drug or amount used, requiring manual review of itemized bills to arrive at specific data needed for the required reporting. For example, an inpatient facility may bill a revenue code (ex. Rev 250 for acetaminophen costing 1 cent and the same revenue code 250 for an antibiotic that costs \$1000).

In summary, due to variances in facility contracts and basis for reimbursement, prevalence of use of DRGs, lack of granular drug level reporting, and manual reporting needs, inpatient medical benefit drugs should not be included in the reporting.

Rebate request: In section (2)(l)(B), (C), and (D), the Division requests payors include the “net impact of any rebate or other price concessions.” We request the Division remove this language as it exceeds the scope and granting authority provided in HB 4005. A previous comment from PhRMA states, “manufacturers pay billions of dollars in rebates each year” and asked those rebates be included in the rate filing reports required by payors. If that statement is accurate and the Division intends to exceed the scope of the language passed in HB 4005, those rebates offered by manufacturers should also be included in their required reporting to reflect the true cost to consumers. While manufacturers do offer rebates on some prescription drugs, a recent analysis conducted by Milliman, an actuarial consulting firm, found that 89% of all prescription drugs written in 2016 had no rebates, the vast majority of which include generic drugs that generally lack rebates and only 13% of the 2016 protected class drugs analyzed had manufacturer rebates.¹

The legislative intent of HB 4005 is to “increase the transparency of pharmaceutical drug prices in Oregon” as stated in the legislative staff summary.² Requiring the addition of rebates only on one side of the equation (the health plan) and not on the drug manufacturer who offers the rebates does not comply with that legislative intent. If complete transparency is our goal in this rulemaking, it is imperative consumers realize the direct list price of a prescription drug that is set by drug manufacturers alone. Rebates offered by manufacturers, negotiated by third parties and received by health plans have absolutely no effect on the original list price.

In conclusion, we believe the Division should remove the proposed language requiring health plans to include rebates when identifying the 25 most costly drugs, the 25 drugs that have caused the greatest increase in total plan spending from one year to the next and from the impact of costs of prescription drugs on premium rates. Requiring this information exceeds the scope of HB 4005 and will not elicit total transparency of the actual drug price on consumers.

¹ Milliman Report: Prescription Drug Rebates and Part D Drug Costs.

² <https://olis.leg.state.or.us/liz/2018R1/Downloads/MeasureAnalysisDocument/40459>

Thank you for the opportunity to provide comments on the proposed rulemaking language and we look forward to working with the advisory committee in the days and months to come.

Sincerely,

A handwritten signature in blue ink that reads "Jennifer Baker". The signature is written in a cursive, flowing style.

Jennifer Baker, JD
Regulatory Affairs
Cambia Health Solutions