April 29, 2021

Re: Oregon Senate Bill 844, “Establishes Prescription Drug Affordability Board in Department of Consumer and Business Services”

Dear Honorable Members of the Oregon Joint Ways & Means Committee:

NICA is a nonprofit trade association and the nation’s voice for community-based infusion providers that offer a safe, more efficient, and more cost-effective alternative to hospital care settings for provider-administered medications. NICA’s efforts are focused on addressing and overcoming challenges and threats to the sustainability of the most affordable care setting for provider-administered medications. Our goal is to help key decision-makers understand the value of receiving provider-administered medications in non-hospital care settings and preserve this vital delivery channel.

NICA supports policies that improve drug affordability for beneficiaries, improve price transparency, and support expanded access to safe, consistent, high-quality care for consumers. To this effect, our organization writes to express concerns with Oregon SB 844, which would establish a Prescription Drug Affordability Board responsible for implementing an Upper Payment Limit (UPL) for drugs that the board believes will cause affordability challenges for Oregon patients and the healthcare system.¹ We applaud Oregon lawmakers for attempting to address drug costs for patients. However, not only would the UPL proposal of SB 844 fail to achieve this goal, but it would also harm the very vulnerable groups it intends to serve. In practice, we believe this legislation would hinder patient access to life-saving medications by disrupting the delicate economics of medical benefit drug delivery and putting smaller, community providers—that represent the lowest-cost care setting for these expensive medications—out of business.

Patients navigating complex and chronic conditions, such as rheumatoid arthritis, autoimmune disorders, Crohn’s disease, and gout, often rely on infusion treatments. Generally, when a patient and provider decide a biologic is the most appropriate treatment option, the patient has already exhausted all available conventional drugs across an arduous disease management journey. Given the expensive nature of infusion drugs (e.g., biologics), patients relying on these medications benefit from receiving treatment at non-hospital infusion centers, one of the lowest-cost sites of care available in our healthcare system.

Some of the most medically vulnerable Oregonians rely on one of the 24 community-based infusion centers across the state to manage their conditions outside of the hospital setting. These 24 infusion centers deliver tremendous value in optimizing health outcomes, maximizing quality of life and minimizing the physical, emotional, and economic burdens of disease. These infusion centers are critical in improving affordability and access to the right medication at the right time in the most cost-effective setting, enabling patients to achieve a state of medical stability and manage their disease primarily with a medical benefit drug. When these patients can achieve and maintain a state of medical stability, they

¹ Oregon. Legislature, 81st Legislative Assembly. SB844, Establishes Prescription Drug Affordability Board in Department of Consumer and Business Services. Available at.
https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/SB844
minimize health care service consumption, saving beneficiaries, employers, payors, and the state millions of dollars annually. Losing capacity in any one of these 24 centers would be detrimental to patient access and would force patients in rural or less-populated areas to travel great distances for an infusion treatment. The result will be poorer health outcomes, reduced quality of life, increased burdens of disease, increased health spend, and reduced or lost ability to continue working.

In terms of medical benefit drugs, infusion providers generally acquire, administer, and bill drugs through a buy-and-bill model, and are reimbursed for the drug (“drug payment”) as well as a small, undervalued payment for the professional services required to administer the drug (“admin payment”). Providers' highest possible admin payment under Medicare Part B is about $210 for a three-hour infusion service that, on average, costs an infusion center $1,200 to furnish. To maintain economic viability, infusion centers must rely on their drug payments to offset the incredible cost-reimbursement disparity on the professional services side. Given that these administration payments are grossly insufficient in covering the cost of furnishing these specialty medications, drug payments are the economic lynchpin to offset practice expenses, including inventory management, staff salaries, and office space. In the absence of a supplemental payment or increased professional service reimbursement, SB 844’s plan to disrupt drug reimbursement for providers would force most of the state’s community-based infusion centers to shutter their doors, forcing their patients into more expensive hospital care settings.

In practice, SB 844 would limit how much infusion centers are reimbursed for the drugs they furnish and disrupt this delicate cost-reimbursement equilibrium. The bill proposes establishing a UPL, which would limit how much health plans and private insurers in the state pay for a drug, but it would not change the actual cost of drug acquisition. Though well-intended, this bill would harm infusion providers and their patients by jeopardizing the economic viability of the infusion center care model, leading to closures across the state, delaying patient access to life-saving medications, and in turn, pushing patients into a more expensive care setting. As Dr. Jasmine Chaudhary from Cascade Infectious Diseases & Infusion in Salem, Oregon stated it in her testimony at the Senate Committee on Health Care, “[providers] could potentially face cuts in reimbursement which would not cover acquisition costs and this could potentially lead to closure of these clinics and thus further obstructing access. So where would the patients go if that were to happen?”

Establishing UPLs on drugs without understanding and considering the economic implications for the infusion delivery channel can only lead to reduction in available sites of care, drastically limiting patients’ ability to manage their chronic conditions or autoimmune diseases. Any policy changes that reduce a patient’s ability to access the right care at the right time will increase long-term costs. Any policy changes that would disrupt the viability of non-hospital care settings for provider-administered drugs will restrict,

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delay, or disrupt hundreds of thousands of patients’ access to care, diverting any short-term savings into hospital care settings at a significant increase per patient, per treatment cost.

We suggest that Oregon lawmakers explore other options for reducing prescription costs for patients while improving access to high-quality care in low-cost settings. Two potential solutions include: (1) focusing on the patient out-of-pocket responsibility by ensuring that all copayments count (SB 560 is a current bill intended to ban copay accumulator policies); or (2) ensuring—through payor/PBM transparency legislation—that rebates and discounts are passed along to patients and do not stop at insurers and pharmacy benefit managers (PBMs).

On behalf of the providers who furnish infusion medications in non-hospital care settings and the patients they serve, we implore you to further evaluate the unanticipated and devastating effects this legislation would have on the very groups SB 844 intends to serve. We understand that affordability and accessibility of drugs are significant challenges that need to be addressed, but we must do so without compromising the most affordable care settings available to Oregon patients.

Should you have any questions, comments, or require additional information, please feel free to contact me directly at kindyl.boyer@infusioncenter.org or 512-402-6955.

Sincerely,

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