Wolf, Sheldon

From: Megan Houn <Megan.Houn@bcbsnd.com>
Sent: Tuesday, March 7, 2023 9:50 AM
To: NDLA, S HMS
Subject: 1095 Testimony

Would you mind posting or emailing to committee members please?

1095 Testimony

Chairman Lee and Members of the Senate Human Services Committee,

Blue Cross Blue Shield of North Dakota (BCBSND) respectfully requests a Do Not Pass for House Bill 1095 in its current form. We view this as an insurance mandate which would require all carriers to create a new program to match the proposed legislation and respectfully ask that you add the PERS trial to identify utilization and administrative costs. However, we have been in communication with the DOI and if they accept our current program as fulfilling the requirements of this proposed legislation, then we will be in support.

BCBSND already has a medication optimization program in place at no cost to our members, which includes around 175 local pharmacists across the spectrum of pharmacies in the state (hospital, long-term care, stand-alone, chain, etc).

Our program uses an algorithm that identifies eligible members and then pushes those members out to the local pharmacists for contact. This algorithm is more comprehensive than the criteria outlined in HB 1095 and allows our program to account for network adequacy by utilizing tele-pharmacy. For example, suppose there is not an enrolled provider doing these services in Glen Ullen. In that case, we will have a pharmacist from another region reach out to the area without a provider.

As this program functions similar to that of one laid out in 1095, and would likely meet the intent behind the legislation, our concerns are limited to how 1095 wishes these programs would be implemented.

Firstly, in relation to member capture. Specifically, we are concerned about how we can capture all of the fully insured members who meet the criteria laid out in the bill. For example, we would not have insight into medications for which a member is paying cash, using GoodRx or manufacturer coupons, or for medications, they pick up over the counter. Another potential gap is that we do not have access to the Prescription Drug Monitoring Program (PDMP). As such, we can not have insight into all controlled substances a member is using if that member chooses to pay cash. Also, how do medications filled through Indian Health Services work? What about patients that switch insurance? If passed into law, we would not have knowledge into the previous medication lists for those members and we then would have difficulty complying with this regulation.

Secondly, we have concerns surrounding the provider directory. Since the passage of the federal No Surprises Act, we have been required to supply and maintain a provider directory. Despite multiple efforts (and modalities) to encourage providers to update their information, over 90% still have not responded. Our suggestion would be to require the pharmacists to be responsible for updating their own directory entries or have joint responsibility. Additionally, the directory calls for components we do not typically collect, one being gender which we think would fit better as an optional data field.

Thirdly, under 43.15-31.2,

> "Pharmacists are required with each prescription dispensed to explain to the patient or the patient's agent the directions for use and a warning of the potentially harmful effect of combining any form of alcoholic beverage with the medication and any additional information, in writing if necessary, to assure the proper utilization of the medication or device prescribed."

Because of this, we have concerns relating to the vagueness in the wording found on Page 3, section 4b.

> "Health carriers shall reimburse facilities for covered services provided by network pharmacists within the pharmacists' scope of practice per negotiations with the facility."

This vagueness could result in carriers reimbursing pharmacists for services that are part of their required scope of service under 43.15-31.2 instead of for the benefits intended by this program. When we look at Hawaii, where the coding NDPhA wants is used, data shows it will double the cost of our current program.

Additionally, we request that line 9 on Page 3 be removed. Patients with hospital admissions should already receive discharge counseling on their medications upon their discharge. Further, members that were admitted to the hospital who would benefit from this service will likely already qualify under sections A, C, or D regardless of the number of hospitalizations. However, members that don't meet criteria A, C, or D would not benefit from this service but would qualify solely for hospital admissions. An example would be a young person who has been admitted for three "bad luck" incidents, perhaps a broken leg, appendicitis, and concussion, who will qualify for this program but, due to the nature of their hospitalizations, will not benefit. So section B is unnecessary as those who would benefit from the program will already meet the criteria elsewhere and those who remain would not benefit.

Lastly, we request two cleanup amendments. The first is on Page 3, line 28 the word medical should be removed as our understanding is that it was inadvertently missed in the House amendment. Secondly, we request that line 12 on Page 3 be stricken. These programs come at a cost; not everything can be changed and updated quickly. There is a cost to BCBSND and our members every time something is added or changed, and for each patient encounter, it isn't administratively feasible to leave it open-ended.

It is for the above-mentioned reasons that BCBSND respectfully requests a Do Not Pass for House Bill 1095 in its current form.

Thank you.

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