House Industry, Business and Labor Committee
HB 1584
February 11, 2025 - 2:30 pm

PCMA Testimony in Opposition to HB 1584

GOOD AFTERNOON CHAIRMAN WARREY, VICE CHAIRMAN JOHNSON AND COMMITTEE MEMBERS:

My name is Michael Power and I represent the Pharmaceutical Care Management Association also referred to as PCMA. PCMA is the national trade association for pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 275 million Americans with health coverage provided by large and small employers, health insurers, labor unions, and federal and state-sponsored health programs.

At this time, PCMA appreciates the opportunity to provide comments on HB 1584 and respectfully opposes it. This bill changes existing law by making changes to definitions, adding to the list of pharmacy benefit manager prohibited practices, and adds enforcement and penalties for noncompliance.

PBMs exist to make drug coverage more affordable by aggregating the buying power of millions of enrollees through their plan sponsor/payer clients. PBMs help consumers obtain lower prices for prescription drugs through price discounts from retail pharmacies, rebates from pharmaceutical manufacturers, and using lower-cost dispensing channels. Though employers, health plans and public programs are not required to use PBMs, most choose to because PBMs help lower the costs of prescription drug coverage.

In 2020, the cost of health care spending per North Dakota resident was $13,204, which ranks it as the 15th highest in the country[1]Health care costs are already high in North Dakota, and enacting HB 1584 will only exacerbate the problem.

The proposed legislation will change existing North Dakota law by **removing the exclusion** of self-funded health plans organized under the federal Employee Retirement Income Security Act (ERISA) law from the definition of "covered entity." The result of removing the exclusion of ERISA self-funded health plans would open the door to additional government mandates, leading to increased costs for businesses and other employer groups in North Dakota that choose to self-fund health benefits for their employees. The legislation could mean that current anti-business laws would now apply to the self-funded market and could cost self-funded health plans in the State of North Dakota **$25 million in excess drug spending in the first year alone and $417 million over the next 10 years**.

It should be noted, the U.S. Supreme Court's 2020 decision in the *Rutledge* case was clear and followed 50 years of federal preemption jurisprudence. States may only regulate self-funded health plans organized under federal ERISA law in very narrow circumstances.

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[1] USA Facts. "Health in North Dakota." 2023.

In 2021, the U.S. Court of Appeals for the 8th Circuit ruled via the *Wehbi* case that certain North Dakota anti-PBM laws may be applied to ERISA plans. However, it should be noted that **a state would not be compelled to regulate said plans**. PCMA believes the *Wehbi* decision was wrongly decided, and may embolden bad public policy, including anti-business laws.

PCMA also has concerns with the additional language added under the definition of "Payment received by the pharmacy benefits manager". For example, "pharmacy price concessions" was added, however, pharmacies do not pay PBMs pharmacy price concessions.

In Section 3, under "Prohibited practices", we also have concerns with the added language dealing with opt-in contracts. There are times in the renewal process when getting a signed contract back from a pharmacy in a timely manner is an issue. This could put both patient access and network adequacy at risk.

In Section 6, dealing with "Enforcement", the new language would allow 'collaboration' with the state board of pharmacy. There is a great need to ensure the protection of competitive and proprietary financial information. Therefore, we are **<u>very concerned</u>** about data and information being shared with the board of pharmacy. It should be noted that the Federal Trade Commission (FTC) has opposed regulatory boards composed of market participants in other industries. There is also a US Supreme Court case in *North Carolina State Board of Dental Examiners v. Federal Trade Commission,* that looked into the question and ruled in favor of the FTC. The Board of Pharmacy is comprised of active market participants whose access to market sensitive data could result in a conflict of interest and undermine competition in the prescription drug marketplace.

Finally, in Section 7, dealing with "Administrative penalties" the monetary and civil penalties are extremely excessive, and the language pertaining to restitution to individuals is puzzling given PBMs do not have direct contracts with individuals/members.

It is for these reasons we are opposed to HB 1584 and we recommend a "do not pass" recommendation.

Thank you for your time and consideration. I would be happy to answer any questions.

North Dakota HB 1584 to Cost the State $417 Million In Increased Prescription Drug Costs

In 2020, health care spending cost $13,204 per North Dakota resident, ranking it the 15th highest-spending state on healthcare.[1] In that same time, North Dakota spent over $289 million on retail prescription drugs in the commercial market.[2] Health care costs are already high in North Dakota, and HB 1584 would only contribute to the problem. The proposed legislation would change existing North Dakota law by **removing the exclusion** of self-funded health plans organized under the federal Employee Retirement Income Security Act (ERISA) law from the definition of "covered entity." The result of removing the exclusion of ERISA self-funded health plans would open the door to additional government mandates, leading to increased costs for businesses and other employer groups in North Dakota that choose to self-fund health benefits for employees. The legislation could mean the current anti-business laws would now apply to the self-funded market.

The core mission of pharmacy benefit managers (PBMs) is to reduce prescription drug costs for health plan sponsors so that consumers have affordable access to needed prescription drugs. PBMs offer a variety of services to their health plan sponsor clients and patients that improve prescription adherence, reduce medication errors and manage drug costs.

Current North Dakota law includes provisions to restrict the use of core PBM tools, including preferred pharmacy networks, utilization management tools, and white bagging. Although some of the provisions are subject to interpretation, expanding just the provisions discussed below to self-funded health plans could cost the State of North Dakota **$23 million in excess drug spending** in the first year alone and **$417 million** over the next 10 years.

Projected 10-Year Increases in Prescription Drug Spending in North Dakota, 2025–2034 (millions)

	Self-Insured Group Market
Restrict Pharmacy Networks	$196
Restrict Utilization Management Tools	$97
Restrict White Bagging	$125
Maximum Costs – Three Provisions	**$417**

Methodology: The methodology used to create these cost projections for adopting AWP and utilization management tools was that used by Visante in the January 2023 paper "Increased Costs Associated With Proposed State Legislation Impacting PBM Tools." The methodology used to create the white bagging cost projections is described in "Appendix: White Bagging Dispensing."

[1] USA Facts. "Health in North Dakota." 2023.

[2] PCMA acquired IQVIA data. The statements, findings, conclusions, views, and opinions contained and expressed in this report are based in part on data obtained under license from the following IQVIA Institute information service: IQVIA PayerTrak data for PCMA, 2022, IQVIA Inc. All Rights Reserved.

PCMA

Bill Provisions Descriptions

Expanded restrictions could limit the use of preferred pharmacy networks, specialty pharmacies, and mail-order pharmacies.

- PBMs require pharmacies to compete on service, price, convenience, and quality to be included in preferred networks. Pharmacies that agree to participate in such arrangements are designated as 'preferred' and become members of a preferred pharmacy network. These types of networks have gained traction among plan sponsors and deliver tangible savings for patients.
- Nearly 80% of employers believe that mail-order specialty pharmacies are the lowest-cost site of service compared with retail community pharmacies and other options.[3] The bill guts the ability for health plans and PBMs to create preferred pharmacy networks for plans by mandating an "any willing provider"(AWP) requirement. According to the Federal Trade Commission[4] and academic analysis,[5,6,7] this type of mandate leads to less competition and higher prices for consumers.
- When applied to specialty pharmacies, the consequences of AWP legislation are even greater. Because specialty drugs are dispensed in such low volumes and target rare conditions, it is infeasible for most retail drugstores to stock these medications and provide the specialized services patients require. States do not legally differentiate specialty pharmacies from traditional pharmacies. These payer-aligned specialty pharmacies must meet payers' terms and conditions to be included in preferred pharmacy networks. Of the roughly 64,000 pharmacies in the U.S., only about 400—less than 1%—are accredited as specialty pharmacies by the independent Utilization Review Accreditation Commission.[8]

Expanded restrictions could limit PBM utilization management tools.

- Utilization management tools like prior authorization and step therapy are widely used by PBM clients to help ensure appropriate and cost-effective use of high-cost drugs. Studies have demonstrated that prior authorization can generate savings of up to 50% for targeted drugs or drug categories.[9] Step therapy has demonstrated savings of more than 10% in targeted categories. These tools are becoming increasingly important in managing the rapidly growing use of high-cost specialty pharmaceuticals. Restricting the use of these tools would raise drug benefit costs for both patients and plan sponsors.

Expanded restrictions could expand the ban on white bagging.

- Under a white bagging model, a specialty pharmacy ships the drug for a given patient directly to the health care provider rather than the provider buying the drug and billing the insurer. The cost of these drugs through specialty pharmacies is lower than through the traditional "buy-and-bill" model.
- Legislation that would bar health insurers from implementing white bagging will seriously undermine the ability of health plans and PBMs to manage their medical specialty pharmacy expenditures, and as a result, drug spending in North Dakota would soar. The use of white bagging has real benefits for patients, providers, and health plan sponsors.

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[3] PBMI. "Trends in Specialty Drug Benefits". 2018.
[4] FTC letter to CMS. "Contract year 2015 policy and technical changes to the Medicare advantage and the Medicare prescription drug benefit programs." Mar. 7, 2014.
[5] Klick, Jonathan and Wright, Joshua D., "The Effect of Any Willing Provider and Freedom of Choice Laws on Prescription Drug Expenditures." Am. L. & Econ. Rev. 192 (2015).
[6] Atlantic Economic Journal. Durrance, C., "The impact of pharmacy-specific any-willing-provider legislation on prescription drug expenditures." 2009.
[7] DHS. Reforming America's Healthcare System Through Choice and Competition. 2018.
[8] URAC. "2022 Specialty Pharmacy Performance Measurement." 2023.
[9] Prime Therapeutics. "Specialty Utilization Management Proves Effective: Ampyra Prior Authorization Improves Safety and Saves Money." 2011.