February 5, 2025

The Honorable Jeff Barta, Chair Industry and Business Committee
The Honorable Keith Boehm, Vice Chair Senate Industry and Business Committee
North Dakota Senate Human Services Committee Members
State Capitol
600 East Boulevard
Bismarck, ND 58505-0360

Re: **SB 2280 – Relating to Prior Authorization for Health and Dental Insurance**
PCMA Testimony in Opposition to SB 2280

Dear Chair Barta, Vice Chair Boehm, and Committee Members:

My name is Michelle Mack, and I represent the Pharmaceutical Care Management Association, commonly 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 SB 2280 and respectfully opposes it. This bill establishes in statute the requirements and restrictions for prior authorization, including process, time frames, appeals, etc.

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.

Prior Authorization Ensures Consistent, Guideline-Based Care While Reducing Costs for North Dakota Payers

Prior authorization is a form of utilization management where a health plan requires pre-approval of a prescription drug. The primary goals are 1) to ensure the appropriateness and suitability of the prescribed medication for the specific patient; 2) to ensure safety; and 3) to reduce costs.

The use of prior authorization in the medical benefit and drug benefit are different. Prior authorization in the medical benefit is for a service and prior authorization use in the drug benefit is for a product – a prescription drug. The difference is important because a drug is typically prescribed for use over a length of time, not just once. Ongoing use of a drug may require monitoring or testing to ensure the drug is safe and effective.

Prior authorization is a tool used for drugs with the following characteristics:

- Dangerous side effects
- Harmful when combined with other drugs
- Should only be used for specific health conditions
- Are often misused or abused
- Have equally, more effective, or more affordable drugs that would work for the majority of patients based on evidence-based drug therapy standards of care

According to the National Academy of Sciences, Engineering, and Medicine (NASEM), "Formularies are used to steer patients and prescribing clinicians toward generic substitutes, biosimilars, drugs with similar therapeutic efficacy for the same disease, or other therapeutic options." Without formulary controls, "insurance premiums would rise," notes NASEM. Prior authorization and step therapy are among the most effective formulary controls, thus prohibiting use of these programs would likely raise premiums. Increased premium costs are passed on directly to North Dakotans who are already feeling the strain from rising costs on their pocketbooks.

Prior Authorization Requirements are Developed by a Panel of Independent Experts.

Health plans and PBMs rely on independent Pharmacy and Therapeutics (P&T) Committees, comprised of independent experts including licensed physicians, pharmacists, and other medical professionals, to develop evidence-based guidelines used in drug management programs—including prior authorization—and to ensure that these management controls do not impair the quality of clinical care.

Every Plan has a Prior Authorization Exceptions Process to Safeguard Coverage of Non-Formulary Drugs when Appropriate.

According to the National Academies of Sciences, Engineering, and Medicines, "Every plan, whether Part D or an employer-sponsored pharmacy benefit, has an exception process that permits coverage of a drug not on formulary or reduces out-of-pocket cost if a prescriber provides information about side effects the patient has experienced from a lower-tiered drug or offers another medical reason for switching."[1] This process safeguards against the use of prior authorization being too restrictive.

Use of Real Time Benefits Tools and Electronic Prior Authorization Ease Provider Burden, Shorten Review Times, and Improve Transparency for Patients.

Any administrative complexities for providers can be minimized by using real time benefit tool technology, which allows prescribers to see the formulary, the patient's cost share, and other requirements at the time of prescribing. Electronic prior authorization (e-PA) is a useful tool that allows insurers and prescribers to communicate electronically instead of using antiquated fax machines and voice calls, which are expensive and time-consuming. According to the most recent data (2019), 75% of pharmacy prior authorizations are fully electronic and use the NCPDP SCRIPT electronic standard for PA.[2] 100% of prescribers should be using these tools.

[1] Making Medicines Affordable: A National Imperative," National Academies of Sciences, Engineering, and Medicine (NASEM), Nov. 2017.
[2] CAQH. 2020. "Issue Brief: The 2019 CAQH Pharmacy Services Index," pg. 2. https://www.caqh.org/hubfs/43908627/drupal/explorations/index/index-pharmacy-brief.pdf
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Industry Concerns with SB 2280

This bill, as drafted, puts all prior authorizations into the same bucket when there is a difference between medical benefits and prescription drug benefits. For example, on page 4, all "adverse determinations" need to be conducted by a licensed physician which would hinder real time benefit tools such as electronic prior authorization. Another example is the requirements for "Urgent" and "Emergency" on pages 6 - 7, as the requirements are geared to medical services. Also, on page 7, dealing with retrospective denial, a prescription drug prior authorization under the prescription drug benefit is never retrospectively denied.

We also have concerns with not being able to use prior authorization for medication assisted treatment on page 7. Drugs for the treatment of opioid use disorder can have dangerous side effects, can be harmful when combined with other drugs, or can be misused or abused, and there is a need for them to be reviewed for appropriate use.

Finally, we have concerns with the language dealing with chronic or long-term care conditions.

PCMA suggests that pharmacy or prescription drugs not be included in the bill. If that is not an option, we suggest creating a separate process for them and requiring mandatory electronic prior authorization use by providers. PCMA and its member companies would be happy to work with all the stakeholders on this matter to further discuss and reconcile the various issues.

Thank you again for the opportunity to comment on SB 2280. We urge a "do not pass" vote.

If you have any questions, please do not hesitate to contact me.

Sincerely,

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