2023 Senate Bill no. 2378
House Human Services Committee
Representative Robin Weisz, Chairman
March 14, 2023

Chairman Weisz and members of the House Human Services Committee, I am Erik Christenson, CEO, Heart of America Medical Center, in Rugby, North Dakota. I testify on behalf of the North Dakota Hospital Association (NDHA). NDHA represents hospitals and health care systems across the state. I testify in support of Senate Bill 2378. We ask that you give the bill a **Do Pass** recommendation.

I wish to share with the house members of the State of North Dakota my experience and knowledge as a pharmacist and administrator in a rural health care setting as it pertains to this legislation. I have practiced as a pharmacist in this state since 1999 and I have been a hospital CEO since 2020. Much of my professional life has been dedicated to providing health care to rural North Dakotans and I have a passion to assure that these patients continue to have viable access to good health care.

In order for rural health care to be able to continue in North Dakota, hospitals will need resources. In particular, human, and financial resources. This legislation will help to assure both of these resources are available to our patients in our communities.

One of the main points made by the insurance companies and their pharmacies is that they can save the health care system and, therefore, our patients and businesses, money. That statement makes sense if it were their goal or mission. However, why is it that they are stepping into the care delivery model in the form of providing medications? One must ask if there is a profit motive in trying to corner this part of the health care delivery model.

Over the past ten years, in which insurance companies and their pharmacies have continued to expand services and force people to their care, the cost of drug expenditures continues to skyrocket. From 2012 to 2022, the annual prescription drug expenditures for Medicare have increased from $67.5 Billion to $143.2 Billion. (CMS, 2023) The narrowed networks created by the large pharmacies, pharmacy benefit managers, and insurers are not allowing for a competitive environment that would help reduce costs. Instead, these

large companies are cornering the market and forcing our communities to pay more for needed medications.

Hospitals are not the bad guys in this equation. In 2010, hospitals and clinical services accounted for 51 percent of the national health care expenditure. (Martin, 2010) In 2020, hospitals and clinical services accounted for 45 percent of the expenditures. (AMA, 2023) In raw dollars that is pay cut of $247 billion. The hospitals are doing their part to cut costs and still provide excellent care. Where is the money going?

In 2022, half of all hospitals had a loss in operations. (Muoio, 2023) This past year, Kaiser Permanente posted a $4.5 billion loss in operations. (Glaidkovskaya, 2023) Over this same year, the big payers or insurance companies had record profits. United Health Group profited $20.6 billion, Cigna profited $6.7 billion, CVS Health profited $4.2 billion, and Humana profited $2.8 billion. (Thomas & Emerson, 2023) The data does not support the premise that these companies will save our communities money. Instead, it appears that they will cherry pick the most profitable parts of the health care delivery model and push those profits to their companies. In the wake of this practice, they will leave the small rural hospitals with scraps to care for the complex health needs of our communities.

One of most critical programs for vulnerable hospitals is the 340B drug pricing program. This program provides significant dollars to rural hospitals allowing them to continue to provide lifesaving services to low-income patients and those living in rural communities. This is a budget neutral program when administrated correctly that is very successful. However, when insurance companies are allowed to corner the medication market and remove the ability of hospitals to purchase medications, these 340B dollars are no longer available to these same hospitals. Instead, the insurance company and their own mail order pharmacies are able to capture these drug rebates. In fact, a recent analysis indicated that pharmacy benefit manager-controlled pharmacies operated by Walgreens, Caremark, Express Scripts, and OptumRx have siphoned away $2.58 billion from the 340B program. (Okon, 2022) That is $2.58 billion that will not be used to help vulnerable or rural patient populations.

You will hear the insurers talk about the increased charges by hospitals for these medications. However, they are not comparing apples to apples. What a hospital charges has little to do with the final costs of health care. What determines the costs of health care is the contractual agreement with the payer. The vast majority of hospital bills are paid through a payer such as Medicare or commercial insurance. These insurance companies have contractual agreements that determine the reimbursement for products and services rendered. It does not matter whether a hospital charges $5,000 or $500 for a drug. If the

insurance company pays the hospital $350, that is what the hospital will get. Contractual write-offs are a big part of the hospital financial system. When an insurance representative is complaining that the hospital is getting paid too much for medication, they are complicit with that payment.

Finally, I want to highlight the problem of allowing insurers to enforce limited access to medications in the form of mail order delivery by summarizing the experience of a North Dakota hospital infusion center. In many cases, the process set up by the insurance company requires the hospital to get prior authorization 10-15 days before initial shipment. It then takes another 3-5 days to process the order. Finally, there must be an authorization of shipment with the patient. It generally requires the hospital to contact the insurer 6-10 times during this set up process and about 8 hours of time on the phone to complete. In many cases, the medication shipment is delayed or interrupted during this process. There are documented cases of treatments being delayed due to this inefficient and unnecessary process. In the end, this process costs the patient in time due to rescheduled appointments and quality in delayed care. The hospital must spend more resources to accomplish this process. A recent survey found that the white bagging process increases hospital expenditures by $310 million. (Vizient, 2021) The insurance company makes extra profit by cornering the medication market and drug rebates, but they are not ultimately responsible for the patient. The hospital must pay more to provide the appropriate care for their patients.

In summary, I support the passage of this legislation as I feel that it is important to assure that our citizens have access to good care and that large out of state companies do not inhibit that access. This bill will support rural hospitals and help assure that we have access to the medications we must provide to our patients. This access must be readily available under normal supply chains and not limited in order to support the bottom lines of big business. There is good reason to believe that limited drug delivery models do not save money for the patients or the community as a whole and, in fact, can hamper affordable care. Good health care is important to North Dakotans, and I feel this bill will help to assure good health care in our state.

Please give the bill a **Do Pass** recommendation. I would be happy to respond to questions.

Respectfully,

Erik Christenson, CEO
Heart of America

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