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Senate Human Service Committee – SB 2378
Madam Chair - Senator Judy Lee
Wednesday February 8, 2023

Madam Chair and members of the committee, for the record, my name is Mike Schwab, Executive Vice President of the North Dakota Pharmacists Association. We are here today in support of SB 2378.

SB 2378 is looking to address a number of problems and concerns many healthcare providers are experiencing as it relates to clinician administered drugs and the patient care process. Prior to last session, our office was approached with a request to address what we in the world of pharmacy call "white bagging" and "brown bagging" issues. We had enough on our plates last session, the request came late and we ran out of time. However, since last session, we have heard from members in all parts of the state regarding an increase in insurance mandates requiring patients to have their therapies/medications exclusively dispensed by an insurer or pharmacy benefits manager (PBM) mail order pharmacy or PBM mail order affiliates.

It is important to note, the big three insurance companies are all now vertically integrated and control 80% of the health plan pharmacy benefit market. The big three are CVS/Caremark/Aetna (#4 on Forbes), United Health/Optum Rx (#5 on Forbes) and Cigna/Express Scripts (#12 on Forbes). They are all in the business of pharmacy owning mail order pharmacies, brick and mortar pharmacies and specialty mail order pharmacies.

What is "white bagging"? This process happens when a PBM or insurer mandates certain drugs are to be delivered to a healthcare practice setting which are then supposed to be administered to the patient. The drugs have to come from an external source which is most often the PBMs mail order pharmacy or PBM affiliate pharmacies. This process causes numerous issues and concerns for healthcare providers and patients. While PBMs argue that white bagging lowers healthcare costs (more on this later), healthcare providers say the practice captures more revenue for the PBMs and may violate patient standards of care.

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White bagging can also bypass pharmacy safety checks, health system planning, supply chain integrity and interferes with the care planning processes. There is a high level of coordination and timing that has to take place with white bagging policies as well. In addition, dosing errors, delivery delays, lost shipments and receiving the wrong drug happens which negatively impacts patient outcomes, delays patient care, may require another appointment and can create drug waste. There are a whole host of other patient and clinical considerations to think about as well. Those considerations include the inability to adjust drug dosages in response to urgent laboratory or clinical findings. When these types of issues happen due to the insurer mandated requirement, we are actually increasing costs.

What is "brown bagging"? This process is similar to white bagging with one main difference. In this case, the drug comes directly to the patient and is in the patient's custody. The many reasons listed above related to white bagging apply to brown bagging as well. However, there are a couple of additional important points worth noting. Under this process, there are elevated safety and product integrity concerns. A provider's liability risk is also elevated under these types of patient steering arrangements.

Now, let's circle back to claims made by the PBMs that these types of mandated requirements save money. In 2018, the Auditor of the State of Ohio produced a State Report which found discriminatory reimbursement practices because the PBMs compensated their affiliate pharmacies at a higher rate than other providers. This same type of practice has been found to be taking place in many other states as well. Arkansas for example found the PBMs were steering patients to its wholly owned affiliate so that it could pay itself more and was in fact paying itself more. An analysis in Florida in 2020 showed PBM affiliated pharmacies were making 18x to 109x more profit over the cost of the drugs than the typical pharmacy. The State of Oklahoma also found PBM owned and affiliated pharmacies were reimbursing themselves at higher rates. Minnesota, Wisconsin and other states have expressed concerns over the practice of PBMs steering patients to PBM-owned pharmacies.

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There are others who would like to testify today so let me conclude by asking once again for your support of SB 2378. When it comes to clinician administered drugs, they should be dispensed as close to the patient point of care as possible. We should do our best to support product integrity and minimize as many risks and safety concerns as possible for patients. Thank you for your time. I will try to do my best to answer any questions.

Respectfully submitted,

Mike Schwab

Mike Schwab
NDPhA - EVP