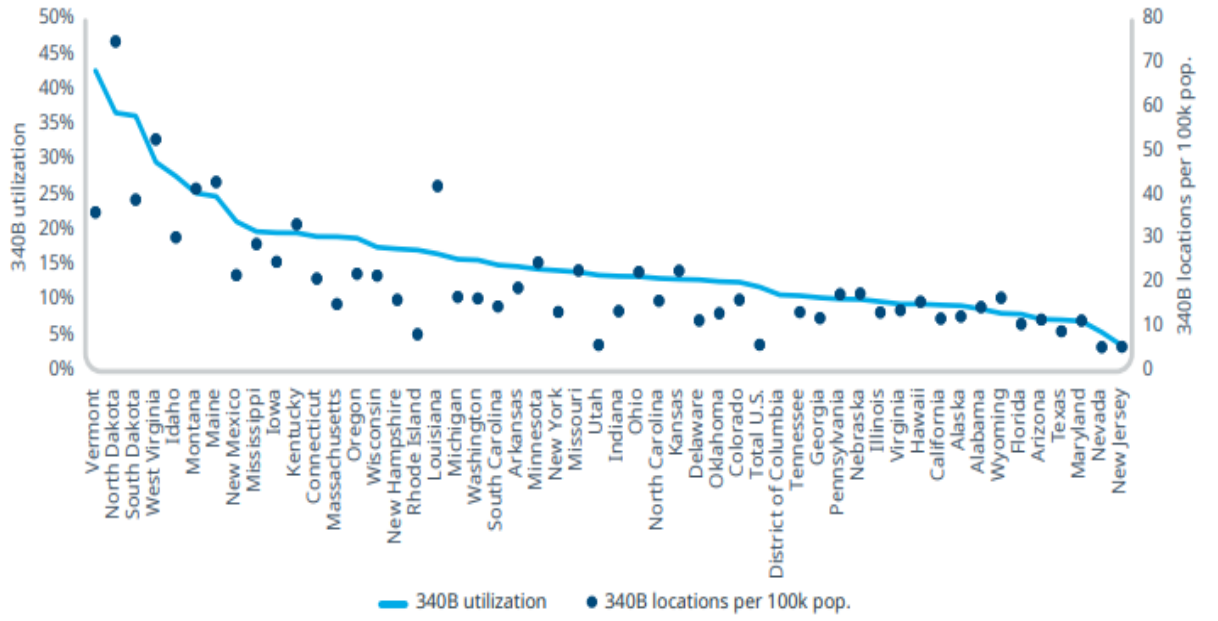
Good morning, Madam Chair and members of the Senate Human Services Committee. My name is Megan Hruby and I am here on behalf of Blue Cross Blue Shield and our over 450,000 members statewide.

I want to take a few minutes to share a couple of points that may not have been mentioned today. I appreciate the committee's patience and thoughtfulness as we navigate a really important issue.

A few areas for your consideration:

1. According to a recent study, North Dakota ranks second in the nation in 340B utilization, highlighting the significance of the program in our state.

Appendix figure 1: 340B utilization and number of 340B locations per 100k population by state



2. That same study estimates that if this bill passes allowing for more pharmacies to participate as a contract pharmacy, North Dakota's 340B revenue will grow to nearly $100 million. The study also estimates that eligible claims will grow from approximately 37% to 65%; which is over 20% higher than any other state's utilization.

3. According to Minnesota's 340B report, commercial payers paid 54% of 340B revenue. 340B revenue is the difference between payments received and the discounted price. Minnesota's 340B Legislative Report 2024. If we apply Minnesota's 54%, this bill will potentially cost North Dakota commercial carriers, and by proxy, policy holders, including BCBSND over $50 million. In reality, because of the lack of information, we simply don't know if these numbers are good estimates of impact or inaccurate representations.

4. If we review the broader impact of this bill and the entire pharmacy legislative landscape, North Dakota has other pharmacy protection and 340B laws in place that other states, including Minnesota, do not, including:

    a. The Any Willing Pharmacy law passed in the early nineties which prohibits a carrier from forming networks that would use a non-340B pharmacy to save money for our members.

    b. HB 1492 passed in 2021 which requires retail price reimbursement for 340B drugs no matter the purchase price for the covered entity or contracted pharmacy. An example of this is if the covered entity acquires Humira, a specialty drug for rheumatoid arthritis, for a penny under 340B pricing, carriers are required to reimburse the full $87000 per treatment retail price pursuant to Section 19-02.1-16.5 of the North Dakota Century Code. If we were to meet in the middle, at $3500 for example, the hospital or covered entity would still receive funding to improve access and BCBSND members would also see a cost savings.

    c. There are gag clauses that prevent insurance companies from asking pharmacies and hospitals about 340B claims to understand the scope and impact of the 340B program.

However, I'm not here today to debate or ask you to change any of that. I'm here asking for transparency and reporting on the 340B program in North Dakota. As it stands today, there is no accurate picture of the impact of 340B on North Dakotans. We have no idea how many covered entities or contracted pharmacies there are, how much funding they are getting from carriers or any other entity, and very few covered entities or contracted pharmacies report on how they are improving access for underserved populations (which is the intent of the program from its inception.) According to state law, we aren't allowed to ask, despite paying for over half of the program. We cannot honestly start thoughtful policy conversations about whether or not the 340B program is "out of control" if we don't have any information on the scope of the program in our state. Therefore, we respectfully

request that the legislation be amended to include reporting requirements and would be happy to provide recommendations upon request.

With that Madam Chair, I will stand for any questions.