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.