Prepared by the Legislative Council
staff for Representative Hendrix
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Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO
FIRST ENGROSSMENT

ENGROSSED SENATE BILL NO. 2370

Introduced by

Senators Cleary, Dever, Mathern

Representative McLeod

A BILL ~~for an Act to amend and reenact section 54-52.1-04.18 of the North Dakota Century Code, relating to health insurance benefits coverage of insulin drugs and supplies.~~ for an Act to create and enact a new chapter to title 26.1 of the North Dakota Century Code, relating to prescription drug transparency reporting under the federal drug discount program; to provide for a report; to provide a penalty; and to provide for application.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

~~**SECTION 1. AMENDMENT.** Section 54-52.1-04.18 of the North Dakota Century Code is amended and reenacted as follows:~~

~~**54-52.1-04.18. Health insurance benefits coverage - Insulin drug and supply out-of-pocket limitations. (Expired effective July 31, 2025)**~~

~~1. As used in this section:~~

~~a. "Insulin drug" means a prescription drug that contains insulin and is used to treat a form of diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes insulin in the following categories:~~

~~(1) Rapid-acting insulin;~~

~~(2) Short-acting insulin;~~

~~(3) Intermediate-acting insulin;~~

~~(4) Long-acting insulin;~~

~~(5) Premixed insulin product;~~

~~(6) Premixed insulin/GLP-1 RA product; and~~

~~(7) Concentrated human regular insulin.~~

~~b. "Medical supplies for insulin dosing and administration" means supplies needed for proper insulin dosing, as well as supplies needed to detect or address medical emergencies in an individual using insulin to manage diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes:~~

~~(1) Blood glucose meters;~~

~~(2) Blood glucose test strips;~~

~~(3) Lancing devices and lancets;~~

~~(4) Ketone testing supplies, such as urine strips, blood ketone meters, and blood ketone strips;~~

~~(5) Glucagon, in injectable and nasal forms;~~

~~(6) Insulin pen needles; and~~

~~(7) Insulin syringes.~~

~~c. "Pharmacy or distributor" means a pharmacy or medical supply company, or other medication or medical supply distributor filling a covered individual's prescriptions.~~

~~2. The board shall provide health insurance benefits coverage that provides for insulin drug and medical supplies for insulin dosing and administration which complies with this section.~~

~~3. The coverage must limit out-of-pocket costs for a thirty-day supply of:~~

~~a. Covered insulin drugs which may not exceed twenty-five dollars per pharmacy or distributor, regardless of the quantity or type of insulin drug used to fill the covered individual's prescription needs.~~

~~b. Covered medical supplies for insulin dosing and administration, the total of which may not exceed twenty-five dollars per pharmacy or distributor, regardless of the quantity or manufacturer of supplies used to fill the covered individual's prescription needs.~~

~~4. The coverage may not allow a pharmacy benefits manager or the pharmacy or distributor to charge, require the pharmacy or distributor to collect, or require a covered individual to make a payment for a covered insulin drug or medical supplies for insulin dosing and administration in an amount that exceeds the out-of-pocket limits set forth under subsection 3.~~

~~5. The coverage may not impose a deductible, copayment, coinsurance, or other cost-sharing requirement that causes out-of-pocket costs for prescribed insulin or medical supplies for insulin dosing and administration to exceed the amount set forth under subsection 3.~~

~~6. Subsection 3 does not require the coverage to implement a particular cost-sharing structure and does not prevent the limitation of out-of-pocket costs to less than the amount specified under subsection 3. Subsection 3 does not limit out-of-pocket costs on an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor. This section does not limit whether coverage classifies an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor as a drug or as a medical device or supply.~~

~~7. If application of subsection 3 would result in the ineligibility of a health benefit plan that is a qualified high-deductible health plan to qualify as a health savings account under section 223 of the Internal Revenue Code [26 U.S.C. 223], the requirements of subsection 3 do not apply with respect to the deductible of the health benefit plan until after the enrollee has satisfied the minimum deductible under section 26 U.S.C. 223.~~

~~8. This section does not apply to the Medicare part D prescription drug coverage plan.~~

SECTION 1. A new chapter to title 26.1 of the North Dakota Century Code is created and enacted as follows:

Definitions.

For purposes of this chapter:

1. "Contract pharmacy" means a pharmacy that has a contract with a covered entity to receive and dispense drugs to the covered entity's patients on its behalf.
2. "Covered entity" means an entity participating or authorized to participate in the program.

3. "Department" means the insurance department.

4. "Drug manufacturer" means the entity that holds the national drug code for a drug, which is engaged in the production, preparation, propagation, compounding, conversion, or processing of the drug or which is engaged in the packaging, repackaging, labeling, relabeling, or distribution of the drug. The term does not include a wholesale drug distributor or retail pharmacy licensed in this state.

5. "Health care facility" means those facilities licensed under chapter 23-16.

6. "Health insurer" means any entity that provides health insurance in this state. The term includes an insurance company, prepaid limited service corporation, a fraternal benefit society, a health maintenance organization, a nonprofit health service corporation, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

7. "Pharmacy benefits manager" has the same meaning as in section 19-03.6-01.

8. "Program" means the federal drug discount program under 42 U.S.C. 256b.

Prescription drug transparency - Report.

1. The commissioner shall:

a. Prescribe the manner in which required reports under this section are submitted to the department.

b. Beginning May 1, 2027, publish annually on the department's website a summary of the information in the reports received by the department under this section.

c. Beginning June 1, 2027, report annually to the legislative management a summary of findings of the reports received by the department.

2. The commissioner may adopt rules to carry out the responsibilities of this chapter.

3. A health care facility, contract pharmacy, or federally qualified health center participating in the program shall report annually to the department:

a. Information describing how the entity's participation in the program benefits its community by using savings from the program to fund, in whole or in part, services that support community access to care, which the entity could not continue without savings from the program. The report must include information relating to charity care, prescription assistance programs, investments in health care workforce development, the total annual costs in excess of Medicaid and

Medicare payments, examples of subsidized services, and the entity's low-income and uninsured volume.

b. An accounting of any amount of program savings not used within this state.

c. The annual estimated savings from the program to the entity, comparing the acquisition price of drugs under the program to the group purchasing organization pricing. If the group purchasing organization pricing is not available for a drug under the program, the acquisition price for that drug must be compared to a price from another pricing source.

d. A comparison of the entity's estimated savings under the program to the entity's total drug expenditures.

e. A description of the entity's internal review and oversight of the program, which must meet the requirements of federal rules and compliance guidelines.

f. The total aggregated payments made by the entity to contract pharmacies for program services, if any.

4. A drug manufacturer participating in the program shall report annually to the department:

a. The aggregate rebate, discount, or other financial incentive amounts or payments provided to health insurers.

b. All trial data, including negative results and effects for any program drug.

c. Any government subsidy, tax incentive, or grant received for each drug approved for sale in the United States.

5. If a drug manufacturer participating in the program denies a program discount or alters drug pricing, the drug manufacturer shall submit a written explanation of the activity to the department and all affected covered entities.

6. If a drug manufacturer overcharges a covered entity, the drug manufacturer shall disclose the overcharge to the department and fully reimburse the covered entity.

7. A pharmacy benefits manager participating in the program shall report annually to the department the:

a. Aggregate amount charged to employer plans for all drugs listed on respective formularies.

b. Aggregate amount paid to pharmacies that are owned by or affiliated with the pharmacy benefits manager.

c. Aggregate amount paid to pharmacies that are not owned by or affiliated with the pharmacy benefits manager.

d. Aggregate savings from mail order pharmacies, specialty mail order pharmacies, and community pharmacies or hospitals owned by or affiliated with the pharmacy benefits manager.

e. Contract policies that reduce reimbursement to pharmacies for participating in the program.

f. Aggregate amount of program contract rate reductions to pharmacies.

g. Difference in program rates for pharmacies owned or affiliated with the pharmacy benefits manager compared to pharmacies that are not owned or affiliated with the pharmacy benefits manager.

h. Average dispensing fee paid to pharmacies owned or affiliated with the pharmacy benefits manager, including mail order pharmacies, compared to the Medicaid rate of dispensing.

i. Average dispensing fee paid to pharmacies that are not owned or affiliated with the pharmacy benefits manager, including mail order pharmacies, compared to the Medicaid rate of dispensing.

8. A health insurer participating in the program shall report annually to the department:

a. The total of premium dollars collected annually from insured individuals and employers.

b. The total of approved medical claims and prescription claims paid annually.

c. The health insurer's method for using excess revenues to reduce premiums and patient out-of-pocket expenses.

d. Rebates, price protection payments, discounts, and other similar remunerations received from drug manufacturers.

e. Any ownership interest the health insurer has in a pharmacy benefits manager, and if a health insurer has an ownership interest, the amount of revenue the pharmacy benefits manager provides to the health insurer.

f. A description of the health insurer's participation in the program, and to what degree each business segment of the health insurer participates in the program.

g. Aggregate revenue generated from participation in the program.

h. Historical data and trends for employers and patients related to premiums, deductibles, coinsurance, copayments, and any other out-of-pocket expenses.

i. Annual savings from claim denials in the program.

Confidentiality - Exception.

1. A report, document, material, or other information that is provided by a reporting entity to the commissioner in accordance with this chapter is confidential and not subject to section 44-04-18, a subpoena to the department, or a discovery request, or admissible as evidence in a private civil action.

2. The commissioner may disclose on its website a summary of the information in the reports and a summary of the findings of the reports, and use the document, material, or other information submitted in a regulatory or legal action brought as a part of the official duties of the commissioner.

3. A privilege or claim of confidentiality in the document, material, or information is not waived as a result of disclosure to the commissioner under this chapter or as a result of providing or disclosing information to the commissioner.

Civil penalty.

A health care facility, contract pharmacy, federally qualified health center, health insurer, drug manufacturer, or pharmacy benefits manager that violates this chapter is subject to the imposition by the attorney general of a civil penalty not to exceed ten thousand dollars for each violation. The attorney general may waive or reduce a fine under this section upon a finding of good cause, such as excusable neglect or other extenuating circumstances. The fine may be collected and recovered in an action brought in the name of the state.

SECTION 2. APPLICATION. This Act applies to health care facilities beginning on January 1, 2026, and to drug manufacturers, health insurers, and pharmacy benefits managers beginning on January 1, 2027.