54-52.1-04.15. Health insurance benefits coverage - Prescription drug coverage - Transparency - Audits - Confidentiality.

1. If the prescription drug coverage component of a health insurance benefits coverage contract received in response to a request for bids under section 54-52.1-04 utilizes the services of a pharmacy benefits manager, either contracted directly with a pharmacy benefits manager or indirectly through the health insurer, in addition to the factors set forth under section 54-52.1-04 the board shall consider and give preference to an insurer's contract that:
   a. Provides the board or the board's auditor with a copy of the insurer's current contract with the pharmacy benefits management company which controls the prescriptions drug coverage offered as part of the health insurance benefits coverage, and if the contract is revised or a new contract is entered, requires the insurer to provide the board with the revision or new contract within thirty days of the change.
   b. Provides the board with monthly claims data and information on all programs being implemented or modified, including prior authorization, step therapy, mandatory use of generic drugs, or quantity limits.
   c. Describes the extent to which the board may customize the benefit plan design, including copayments, coinsurance, deductibles, and out-of-pocket limits; the drugs that are covered; the formulary; and the member programs implemented.
   d. Describes the audit rights of the board.
2. The board may conduct annual audits to the extent permitted under the contract terms agreed to under subsection 1. The audits must include:
   a. A review of a complete set of electronic prescription coverage claims data reflecting all submitted claims, including information fields identified by the board.
   b. A review of a list of all programs that have been implemented or modified during the audit period under subsection 1, and in connection with each program the auditor shall report on the cost, the cost savings or avoidance, member disruption, the process for and number of overrides or approvals and disapprovals, and clinical outcomes.
   c. Recommendations for proposed changes to the prescription drug benefit programs to decrease costs and improve plan beneficiaries' health care treatment.
3. Information provided to the board under the contract provisions required under this section are confidential; however, the board may disclose the information to retained experts and the information retains its confidential status in the possession of these experts.
4. The board may retain an auditor of the board's choice which is not a competitor of the pharmacy benefits manager; a pharmaceutical manufacturer representative; or any retail, mail, or specialty drug pharmacy representative or vendor.

54-52.1-04.16. Prescription drug coverage - Performance audits.

1. Except for Medicare part D, prescription drug coverage, the board may not enter or renew a contract for prescription drug coverage unless the contract authorizes the board during the term of the contract to conduct a performance audit of the prescription drug coverage and any related pharmacy benefits management services. The contract must provide:
   a. The board must have full access to data regarding:
      (1) The total dollars paid to the pharmacy benefits manager by the carrier and the board;
      (2) The total amount of dollars paid to the pharmacy benefits manager by the carrier which were not subsequently paid to a licensed pharmacy in the state; and
      (3) Payments made to all pharmacy providers.
   b. The board must have full access to data regarding the average reimbursement, by drug ingredient cost, dispensing fee, and any other fee paid by a pharmacy

benefits manager to licensed pharmacies with which the pharmacy benefits manager shares common ownership or control or is affiliated.

c. The board must have full access to data regarding the average reimbursement, by drug ingredient cost, dispensing fee, and any other fee paid by a pharmacy benefits manager to pharmacies licensed in the state.

d. The board must have full access to data regarding any direct and indirect fees, charges, or recoupment, or any kind of assessments imposed by the pharmacy benefits manager on pharmacies licensed with which the pharmacy benefits manager shares common ownership or control or is affiliated.

e. The board must have full access to data regarding any direct and indirect fees, charges, or recoupment, or any kind of assessments imposed by the pharmacy benefits manager, on pharmacies licensed in the state.

f. The contract must provide that all drug rebates, financial incentives, fees, and discounts must be disclosed to the board.

2. The board shall use an independent auditor who has no conflict of interest with the carrier, pharmacy benefits manager, or board. The board's auditor, the insurance department, and the employee benefits programs committee may access any information the board may access under this section. All information accessed by the board, board's auditor, insurance department, or employee benefits programs committee which is trade secret is a confidential record. This subsection does not limit the information required to be disclosed to the board under subsection 1.

3. If the board contracts directly with a pharmacy benefits manager or provides prescription drug coverage through a self-insurance plan, the contract must provide the pharmacy benefits manager shall disclose to the board and the board's auditor all rebates and any other fees that provide the pharmacy benefits manager with sources of income under the contract, including under related contracts the pharmacy benefits manager has with third parties, such as drug manufacturers.

4. Anything the board has access to under this section, the insurance department and employee benefits programs committee has access to.

54-52.1-04.17. Self-insurance health plan - Bank of North Dakota line of credit - Continuing appropriation.

The Bank of North Dakota shall extend to the board a line of credit not to exceed fifty million dollars. The board shall repay the line of credit from health insurance premium revenue or repay the line of credit from other funds appropriated by the legislative assembly. The board may access the line of credit to the extent necessary to provide adequate claims payment funds, to purchase stop-loss coverage, and to defray other expenditures of administration of the self-insurance health plan. All loan funds received by the board from the Bank under this section, not otherwise appropriated, are appropriated to the board for the repayment of claims and other costs of the uniform group insurance program.

54-52.1-05. Provisions of contract - Term of contract.

1. Each uniform group insurance contract entered by the board must be consistent with the provisions of this chapter, must be signed for the state of North Dakota by the chairman of the board, and must include the following:
   a. As many optional coverages as deemed feasible and advantageous by the board.
   b. A detailed statement of benefits offered, including maximum limitations and exclusions, and such other provisions as the board may deem necessary or desirable.
2. The initial term or the renewal term of a uniform group insurance contract through a contract for insurance, health maintenance organization, or self-insurance health plan for hospital benefits coverage, medical benefits coverage, or prescription drug benefits coverage may not exceed two years.
   a. The board may renew a contract subject to this subsection without soliciting a bid under section 54-52.1-04 if the board determines the carrier's performance under the existing contract meets the board's expectations, the proposed premium

CHAPTER 54-52.1
UNIFORM GROUP INSURANCE PROGRAM

54-52.1-01. Definitions.

As used in this chapter, unless the context otherwise requires:

1. "Board" means the public employees retirement board.
2. "Carrier" means:
   a. For the hospital benefits coverage, an insurance company authorized to do business in the state, or a nonprofit hospital service association, or a prepaid group practice hospital care plan authorized to do business in the state, or the state if a self-insurance health plan is used for providing hospital benefits coverage.
   b. For the medical benefits coverage, an insurance company authorized to do business in the state, or a nonprofit medical service association, or a prepaid group practice medical care plan authorized to do business in the state, or the state if a self-insurance health plan is used for providing medical benefits coverage.
   c. For the life insurance benefits coverage, an insurance company authorized to do business in the state.
3. "Department, board, or agency" means the departments, boards, agencies, or associations of this state. The term includes the state's charitable, penal, and higher educational institutions; the Bank of North Dakota; the state mill and elevator association; and counties, cities, district health units, and school districts.
4. "Eligible employee" means every permanent employee who is employed by a governmental unit, as that term is defined in section 54-52-01. "Eligible employee" includes members of the legislative assembly, judges of the supreme court, paid members of state or political subdivision boards, commissions, or associations, full-time employees of political subdivisions, elective state officers as defined by section 54-06-01, and disabled permanent employees who are receiving compensation from the North Dakota workforce safety and insurance fund. As used in this subsection, "permanent employee" means one whose services are not limited in duration, who is filling an approved and regularly funded position in a governmental unit, and who is employed at least seventeen and one-half hours per week and at least five months each year or for those first employed after August 1, 2003, is employed at least twenty hours per week and at least twenty weeks each year of employment. For purposes of sections 54-52.1-04.1, 54-52.1-04.7, 54-52.1-04.8, and 54-52.1-11, "eligible employee" includes retired and terminated employees who remain eligible to participate in the uniform group insurance program pursuant to applicable state or federal law.
5. "Health insurance benefits coverage" means hospital benefits coverage or medical benefits coverage, or both.
6. "Health maintenance organization" means an organization certified to establish and operate a health maintenance organization in compliance with chapter 26.1-18.1.
7. "Hospital benefits coverage" means a plan that either provides coverage for, or pays, or reimburses expenses for hospital services incurred in accordance with the uniform contract.
8. "Life insurance benefits coverage" means a plan that provides both term life insurance and accidental death and dismemberment insurance in amounts determined by the board, with a minimum of one thousand dollars provided for the term life insurance portion of the coverage.
9. "Medical benefits coverage" means a plan that either provides coverage for, or pays, or reimburses expenses for medical services in accordance with the uniform contract.
10. "Member contribution" means the payment by the member into the retiree health benefits fund pursuant to sections 54-52-02.9 and 54-52-17.4.
11. "Member's account balance" means the member's contributions plus interest at the rate set by the board.

Jim Kasper

From: Clark, Jennifer S. <jclark@nd.gov>
Sent: Friday, February 12, 2021 12:31 PM
To: Kasper, Jim M.; Jim Kasper
Subject: HB 1233

Good Afternoon-

Per your request, here is a link to NDCC Chapter 54-52.1, the law relating to PERS uniform group insurance, and here is a link specifically to Section 54-52.1-04.16, the law providing for pharmacy benefits performance audits.

Under Section 54-52.1-04.16, there are three main provisions – subsections 1, 2, and 3.

- Subsection 1 provides PERS may not enter or renew a contract for prescription drug coverage unless the contract authorizes PERS to conduct a performance audit.
- Subsection 2 directs PERS to use an independent auditor in performing a performance audit.
- Subsection 3 provides if PERS contracts directly with a PBM or provides pharmacy benefits through self-insurance, the contract must provide the PBM shall disclose all rebates and other fees that provide the PBM with sources of income.

An observation of mine, although the law provides the contract provisions must provide access for an audit and that the PBM must disclose all drub rebates and fees, the law does not expressly direct PERS to conduct the audit. I would be interested to know whether PERS is conducting the audit they have the authority to conduct.

Iope this information helps-

Jenn

Jennifer Clark
Senior Legal Counsel
jclark@nd.gov
701.328.2916

Kasper, Jim M.

From: Miller, Scott A.
Sent: Monday, March 29, 2021 2:19 PM
To: Kasper, Jim M.
Subject: RE: SHP Agreement/Audit Language--MONDAY MARCH 29, 2021---ATTACHED CONTRACT WITH SANFORD

Representative Kasper –

I apologize if it appears like I am playing games. That is not my intent.

Section 11.2 of the contract with SHP specifically incorporates the State's RFP and SHP's proposal in response to the RFP into the contract. As I stated, that is a common way to incorporate RFP requirements and vendor agreements and concessions into an agreement.

Pages 18-19 of the RFP specifically requires compliance with NDCC sec. 54-52.1-04.16. Question 1112 of the RFP also asked the vendors to respond to whether their proposal complies with NDCC sec. 54-52.1-04.16, to which SHP replied in the affirmative: "The proposal complies with 54-52.1-04.16 by providing the board with full access to the specified data."

Question 1113 of the RFP asked the vendors whether there are any requirements of NDCC chapter 54-52.1 that they could not meet, and why. Again, SHP responded affirmatively that, "Sanford Health Plan can meet all areas of 54-52.1 as specified above."

Because section 11.2 of the contract with SHP specifically incorporates the NDCC sec. 54-52.1-04.16 requirement and SHP's affirmative responses into the agreement, the answer to your question of where in the contract it gives NDPERS the right to conduct an audit under 54-52.1-04.16 is section 11.2 of the agreement.

I provided screen shots of the above portions of the relevant documents, which you can see below.

Scott

Scott A. Miller
Executive Director
North Dakota Public Employees Retirement System

North Dakota Public Employees Retirement System
400 East Broadway Avenue Suite 505| PO Box 1657
Bismarck, ND 58502| Online https://ndpers.nd.gov
P 701.328.3900|**TF** 800.803.7377|**F** 701.328.3920
email scottmiller@nd.gov| **Find us on** facebook

Kasper, Jim M.

From: Miller, Scott A.
Sent: Sunday, March 14, 2021 4:24 PM
To: Kasper, Jim M.; Jim Kasper
Subject: RE: Information Request---FISCAL NOTE ON HB 1233---FROM REP. JIM KASPER--SATURDAY MARCH 13, 2021
Attachments: 21.0147 (HB1233)_PBM Audit_Deloitte Memo_03.01.21.pdf

Good Afternoon, Representative Kasper –

I have attached Deloitte's analysis of the current version of HB 1233. As you can see, they maintain that the audit requirements within HB 1233 remain so broad that they will encompass parts or all of five different "typical" PBM audits. They provided information on what they believe is an accurate range of the market price for each of those types of audits. As with our initial fiscal note, we took the minimum from that range for each of the audits and added them together to get the $375,000 figure. Since you did take out the audit requirements for our Part D providers, we eliminated the cost of auditing two additional providers. So the fiscal note went from $1,125,000 to $375,000.

You had also asked for information on the State's health plan premium spend, and the specific premium paid, for the past five bienniums. That information is below:

IDPERS State Health Plan Premiums

Biennium	Monthly State Premium	Biennium Total Premium	
2019-21*	$1,426.74	$495,238,575	* Estimated
2017-19	$1,240.82	$429,581,811	
2015-17	$1,130.22	$411,419,294	
2013-15	$981.68	$361,669,564	
2011-13	$886.62	$323,497,493	
2009-11	$825.66	$298,066,563	

You had also asked for some information on our deferred compensation and flex-comp programs, which is below.

Deferred Compensation Participating Employer Count	
City	51
County	30
District Health Unit	15
Other Political Subdivisions	38
School District	31
State	98
	263

Delete ···

RE: NEED HELP==AUDITS BY OTHER STATES ON PBMS

GB

Gary Boehler
Wed 2/24/2021 8:13 AM
To: Kasper, Jim M.

Gary Boehler R Ph .vcf
4 KB

***** **CAUTION:** This email originated from an outside source. Do not click links or open attachments unless you know they are safe. *****

Jim,

Here is the shortened version; all are Medicaid related unless I specify otherwise. Hope this helps.

1. Ohio – Medicaid spread pricing of $224 million
2. New York – spread pricing of approximately $300 million
3. North Dakota - $17 million in savings over the biennium
4. Kentucky - $123.5 million in spread pricing
5. Florida - $89 million in spread pricing
6. Michigan - $64 million in spread pricing
7. Pennsylvania – from 2013 to 2017 Medicaid spending more than doubled from $1.41 billion to $2.86 billion. Spread pricing being investigated.
8. Ohio – Bureau of Worker's Compensation - $15.8 million in overcharges.
9. Ohio – Highway Patrol Retirement System being investigated for ESI not following plan guarantees – millions of dollars at stake.
10. Florida – discovered that PBM specialty pharmacies only dispensed 0.4% of prescriptions BUT collected more than 28% of the profits – a perfect example of doing nothing for $$$$$$ in their pockets. Typical middleman game.

This should send the message.

Gary

Gary Boehler, R.Ph.
Dakota Drug, Inc.
Pharmacist Consultant

(800) 437-2018 x6210 Work
(763) 432-4333 Ext. 6210 Work
gboehler@dakdrug.com
1101 Lund Boulevard
Anoka, MN 55303

From: Kasper, Jim M. [mailto:jkasper@nd.gov]
Sent: Tuesday, February 23, 2021 5:12 PM